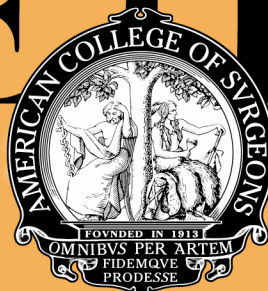


BULLETIN

AMERICAN COLLEGE OF SURGEONS



April 2002
Volume 87, Number 4

The dawn of

ACSPA

American College of Surgeons Professional Association

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About the cover...

The dawn of a more politically active day has arrived at the American College of Surgeons with the creation of a new 501(c)(6) organization known as the American College of Surgeons Professional Association (ACSPA). In "From my perspective" (p. 4), Dr. Russell explains how the ACSPA evolved from a recommendation by the Board of Governors and how it will help the College attain greater political influence. Other potential functions of the ACSPA also are described in the column. (ACSPA logo designed by Bernie Kagel.)

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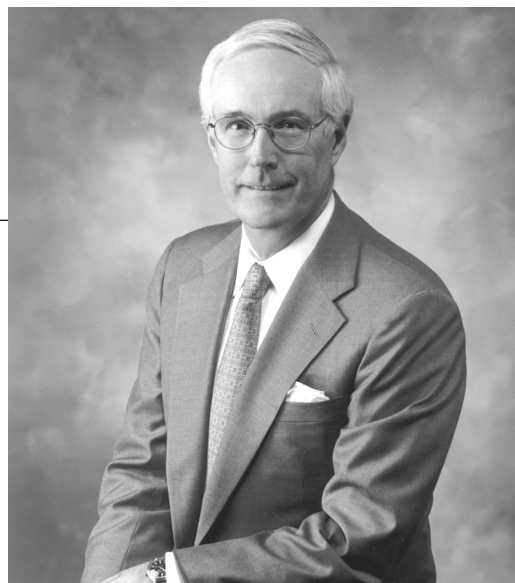
From my perspective

A very significant change in the structure of the American College of Surgeons was made during the February 2002 Board of Regents' meeting. This change—the development of a separate arm of the College that would have 501(c)(6) corporate tax status—was a direct result of action taken by the Board of Governors at their 2001 annual meeting and was approved unanimously by the Regents. This new entity, which has been named the American College of Surgeons Professional Association (ACSPA), will enable us to enhance our visibility in Washington, DC, and will also allow the College to pursue other activities that are currently prohibited under its 501(c)(3) status.

Background

The Governors remain an essential body of the College and truly represent the grassroots of the Fellowship, comprising liaisons from the chapters, regional surgical societies, and specialty societies. Their views and the work of their nine committees have considerable influence in determining the direction and establishing the policies of the College. When the Regents meet, members of the Executive Committee of the Board of Governors are present, and they frequently and forcefully support issues that have surfaced at their meetings.

For an extensive period of time, both the Governors and the Regents have engaged in a sometimes heated debate about the changing political climate with respect to medicine and the difficulties that surgical organizations, such as the College, are having in terms of advocacy in this new environment. Because the College has a 501(c)(3) tax-exempt status, it may only engage in educational and limited lobbying activities. The 501(c)(6) tax-exempt corporate status allows organizations to engage in more in-depth political activities and in ventures that are



“The development of a separate arm of the College that would have 501(c)(6) corporate tax status was a direct result of action taken by the Board of Governors...and was approved unanimously by the Regents.”

banned for associations that have 501(c)(3) tax status.

Some months ago, the Governors presented their case for establishing the 501(c)(6) arm of the College to the Regents, who then appointed a task force chaired by Josef E. Fischer, MD, FACS. This committee was charged with developing and submitting a business plan that would culminate in the creation of a new 501(c)(6) organization affiliated with the College. The task force's plan was completed and underwent appropriate legal review. It was then presented, along with Bylaws that will govern the ACSPA, to the Board of Regents in February. As I men-

tioned previously, the Regents unanimously approved the establishment of this organization.

Not that long ago, this proposal undoubtedly would have been rejected. However, as laws and regulations have continued to have an often adverse effect on surgical practice, the College's Governors and Regents have reconsidered their position about the development of a political advocacy arm. The consensus has shifted away from the view held for several years that such an entity would tarnish the reputation of the College and has now turned toward the perspective that its establishment is clearly necessary.

Purposes and functions

One might ask why a new corporate tax structure is needed for the College to carry out its mission. Part of the answer lies in the changing milieu in which practitioners today, as well as organizations such as the College, find themselves. Clearly, because of the current political climate, we all must carry out activities that seemed unnecessary in the past. Because the political and economic environment in which medicine is practiced has become so complex, the College needs an expanded legislative support program.

The ACSPA will act as a vehicle that will allow us to participate in the legislative arena in a way that was not possible in the past. Many Fellows have voiced their belief that we have had a problem gaining access to influential legislators in the past, and some of our members have suggested that our inability to support candidates has been a real detriment to our influence. Our new tax status will allow us to form a political action committee (PAC) within the ACSPA, which, by allowing us to participate in fund-raising events and otherwise carefully back political candidates, should heighten our visibility and influence in Washington, DC. Further,

we will be able to act as a facilitator in getting other medical organizations and coalitions together to support candidates whose legislative agendas are consistent with the goals of the College. I believe access to political leaders will become increasingly important in the future. Support of politicians will be offered cautiously and always with our objective of putting the interests of our patients in furthering quality of care at the forefront.

Although the creation of a PAC is a significant step for the College, I would like to emphasize that no dues dollars will be spent on its activities and that the College still will have a presence in Washington under its own name. Contributions to the PAC will be totally voluntary. Details about how Fellows can support the PAC will be provided in future articles in the *Bulletin*.

The ACSPA's tax status will also allow the College to have greater flexibility in a number of other areas in the future. For example, given all the new technology and techniques surgeons are expected to master, the College has recently expanded its commitment to education, training, and credentialing of its Fellows, other surgeons, and various nonsurgeon physicians. The presence of a 501(c)(6) entity within the College will make it possible for us to train surgeons to become competitive in the marketplace.

Additionally, as the College reaches out to our chapters and to the smaller surgical societies, we may find ourselves becoming more involved in their management. The cost of these administrative services is often prohibitively expensive for smaller surgical organizations and could very well be supported by the infrastructure of the College.

There are other potential proprietary activities we may add to the list of services the College offers that may amplify the real value of membership in this organization. For instance,

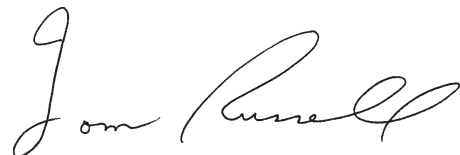
we could expand our insurance program to assist Fellows in obtaining reasonably priced medical malpractice coverage. We are actively pursuing this objective at this time and are engaged in discussions with a number of actuarial firms and insurance companies. This endeavor would clearly fall under the purview of the new ACSPA. Furthermore, 501(c)(6) status will allow us to do much more in terms of financial development, branding and marketing of the College, and public education. At this point, though, our focus will be on using the ACSPA to expand our legislative agenda. All other plans are still very tentative and merely in the conception stage.

Well-conceived program

A great amount of thought and planning has gone into the creation of the ACSPA, particularly with respect to its corporate tax structure.

I want to again emphasize that this idea emanated from the Board of Governors, which considered and reconsidered it over a number of years until they were able to gain strong consensus on how this concept would work. They brought their vision to the Board of Regents and, in an expeditious fashion, the proposal was developed with appropriate legal review and financial planning, culminating in the Regents' unanimous acceptance of proceeding with the establishment of the 501(c)(6) organization.

I am appreciative of all those who worked on this issue to bring the American College of Surgeons Professional Association to fruition. Now our greatest challenge will be to use this vehicle in an effective, ethical, and practical way to advance the mission of the College and to improve the quality of care for our patients.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

FYI: *STAT*

Thomas R. Russell, MD, FACS, and the CEOs of other professional organizations whose members are reimbursed under the physician fee schedule met on March 4 with Bill Novelli, CEO of the **AARP**, in an effort to find common ground on the patient access problems that have already begun to emerge with continued payment reductions. The other groups were the American Medical Association, American College of Physicians-American Society of Internal Medicine, American College of Cardiology, American Physical Therapy Association, and American College of Nurse Practitioners. Also on March 4, Dr. Russell met with Ken Kizer, MD, MPH, chief executive officer of the **National Quality Forum**, a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting.

Escalating activity regarding malpractice issues has prompted the College to examine all aspects of this problem. The tremendous rise in premiums is well known. Another crisis in this arena may be that of **availability of malpractice insurance coverage**. The ACS Division of Member Services is currently seeking comments on this issue. If you are aware of availability problems—not cost issues—please send your comments to memberservices@facs.org.

In keeping with the goal of bringing all surgical organizations and groups related to surgery closer together, Thomas R. Russell, MD, FACS, Executive Director, and R. Scott Jones, MD, FACS, President of the College, have spent considerable time in recent weeks visiting ACS chapters and other groups of importance to the College. Dr. Russell attended a retreat held by the **American Board of Medical Specialties**; the **Hong Kong Surgical Forum**; the annual meetings of the **South-eastern Surgical Congress**, the **Pacific Coast Surgical Association**, the **American Academy of Dermatology**, and the **Society of American Gastrointestinal Endoscopic Surgeons (SAGES)**; and the **Northern Texas** and **Metropolitan Chicago Chapter** meetings. He also gave the **Walter J. Pories Lecture** in Greenville, NC, and the **Emile F. Holman Lecture**, in Stanford, CA; participated in **Grand Rounds at Cedars Sinai** in Los Angeles, **Rush-Presbyterian-St. Luke's** in Chicago, and **Columbia Presbyterian** in New York; and was a **Visiting Professor at Creighton University** in Omaha, NE. Dr. Jones attended the annual meetings of the **South-eastern Surgical Congress**, the **American College of Cardiology**, the **American College of Physicians-American Society of Internal Medicine**, and the **Association of periOperative Registered Nurses**. He also attended the **Southern California**, **West Virginia**, and **Virginia Chapter** meetings.

The American College of Surgeons Eastern States Committees on Trauma is sponsoring **Trauma and Critical Care 2002–Point/Counterpoint XXI**, a continuing medical education course, June 3-5, 2002, in Atlantic City, NJ. The program, which offers 23 hours of CME credit, can be viewed at: <http://www.facs.org/dept/trauma/cme/traumtgs.html>.

Dateline|Washington

prepared by the Division of Advocacy and Health Policy

Legislation introduced to fix Medicare update system

Rep. Nancy Johnson (R-CT), chair of the House Ways and Means Health Subcommittee, introduced HR 3882, the Preserving Patient Access to Physicians Act, on March 6. The bill would implement recommendations made by the Medicare Payment Advisory Commission in its March report to Congress. More specifically, the Johnson bill would repeal the sustainable growth rate (SGR) system on which annual Medicare fee schedule updates are based and that has caused physician payments to fluctuate unpredictably in recent years. It would also set the Medicare fee schedule update at 2.5 percent in 2003, and tie future fee schedule updates to an improved Medicare Economic Index, which measures input cost changes for physicians. Because the SGR is tied to growth in the economy, payments do not reflect the true cost of providing care to patients.

CMS predicts more physician pay cuts

In testimony presented to the House Energy and Commerce Subcommittee on Health on February 14, Thomas A. Scully, Administrator of the Centers for Medicare & Medicaid Services (CMS), projected additional steep Medicare payment reductions for physicians. While explaining to subcommittee members why the physician payment update formula produced a 5.4 percent across-the-board reduction in Medicare payments for 2002, Mr. Scully presented data showing that pay cuts also are predicted for 2003, 2004, and 2005. If these estimates hold true, the fee schedule conversion factor in 2005 will be slightly above \$31, down from over \$38 just last year.

The College and other medical and surgical specialty societies are pursuing a legislative remedy that would restore the 2002 pay cut, and replace the fee schedule update mechanism with one that is more similar to those used for other Medicare provider groups. Surgeons who want to express their concerns to Congress are encouraged to contact their legislators using the College's Web-based Legislative Action Center, at: <http://capwiz.com/facs/home/>.

Liability crisis in spotlight in Nevada

In response to the severe professional liability crisis in Nevada, the Commissioner of Insurance sponsored a public hearing relating to the availability of medical malpractice insurance. Media reports and over 6,000 comments from patients, physicians, professional liability insurance companies, and others were instrumental in convincing state government officials that a crisis exists, and testimony during the hearing reiterated this point.

Stephen Daniel McBride, MD, FACS, President of the College's Nevada Chapter, was the first witness to testify. He addressed the problems that surgeons are having with the availability and affordability of professional liability insurance, noting that many surgeons and high-risk specialists are experiencing premium increases of 300-400 percent. As a result, Dr. McBride noted that 10 percent of general surgeons have left practice in southern Nevada.

ACS Fellow nominated to be the next Surgeon General

Also, coverage for the Level I trauma center in Las Vegas has become more difficult since two of the 12 trauma surgeons have already resigned, and one more is expected to leave in the next few weeks because they cannot obtain malpractice coverage. Information about this hearing is available through the Nevada Department of Insurance Web site at <http://doi.state.nv.us/P&C/MedMal/IndexMedMal.htm>.

Richard Carmona, MD, FACS, a general and trauma surgeon from Tucson, AZ, has been nominated to be the next Surgeon General of the U.S. President George W. Bush announced his nomination at a news conference held at the White House on March 26, 2002. President Bush highlighted Dr. Carmona's experience as a hospital administrator, law enforcement official, and public health and bioterrorism expert as some of the major factors that make him an ideal candidate to lead the country's public health and education efforts. Dr. Carmona's nomination must be confirmed by the U.S. Senate before he can assume the position of Surgeon General, which has been vacant since Dr. David Satcher's term ended in early February of this year. Thomas R. Russell, MD, FACS, Executive Director of the College, attended the event at the White House as a guest of Dr. Carmona. The College provided its strong support for Dr. Carmona's appointment in a February 29 letter to White House Chief of Staff Andrew Card.

College identifies regulatory burden to government

Last December, the Department of Health and Human Services announced that it had appointed an Advisory Committee on Regulatory Reform to suggest streamlining requirements set by the Food and Drug Administration and the CMS. The committee requested and received written comments identifying burdensome regulations and will be holding four public hearings to gather more information before making its recommendations.

In his letter to the committee, Dr. Russell requested that minor modifications be made to two Medicare regulatory requirements that are especially burdensome to surgeons. One is to clarify whether it is necessary for the surgeon to obtain an advance beneficiary notice (ABN) from a patient who is being referred to another physician for a face-to-face service. (The ABN ensures the second physician will be paid by transferring financial responsibility to the patient in the event that Medicare finds the service not to be medically necessary.)

The second issue relates to the 23 national coverage decisions on clinical laboratory test(s) that will become effective this November. Only four of the decisions recognize "preoperative testing" as a reason for doing the tests. For the remaining tests, the surgeon must look up a definitive ICD-9-CM diagnosis code. The College requested that the coverage decisions be clarified to indicate that the preoperative testing is recognized wherever it is appropriate.

What surgeons should know about...

Medicare rules for hospital-based clinics

by Thomas Ault and John Ferman, Washington, DC

On April 7, 2000, the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services, or CMS) published a final rule specifying the criteria that determine whether a service is considered “provider-based.” The rule, which has implications for physicians who practice in academic and hospital-affiliated clinics, was effective for cost-reporting periods beginning on or after January 10, 2001.

According to CMS, the need for the rule emerged as providers adapted to new payment incentives and pressures following implementation of the inpatient prospective payment system (PPS) in 1983, the emergence of integrated delivery systems, and continual pressure to enhance revenues. These factors combined to create incentives for providers to affiliate with one another and to acquire control of nonprovider treatment settings, such as physician offices.

This article answers some of the questions surgeons may have about the rule and its impact on their practices. A summary of the final CMS regulation and of changes made by the Medicare, Medicaid, and State Children’s Health Insurance Program Benefits Improvement Act (BIPA) is included on page 11 of this article.

Q. The provider-based rules apply to hospitals. Why are they important to physicians?

A. If the hospital has purchased a practice, the rules will determine whether care has been provided in a physician’s office or in a hospital outpatient clinic. This, in turn, determines how the service must be

billed. Physician office services are paid under the physician fee schedule. For hospital outpatient clinics, the facility portion of the service is paid under the hospital outpatient PPS and the professional service is paid under the physician fee schedule.

Q. According to the rule, when is a site considered a hospital clinic or a physician’s office?

A. A site is deemed to be a physician’s office when the hospital’s request for hospital-based determination fails to meet one or more of the criteria described in the summary of the final rule on page 11. The entity would *not* be hospital-based, for example, if:

- It is separately licensed (unless the state requires a separate license for hospital clinics).
- It is not wholly owned by the hospital (that is, it is a joint venture between the hospital and the physician).
- Its administrative functions are not fully integrated with the hospital’s.
- Its clinical services are not fully integrated with the hospital’s.
- There is no affiliation acknowledgment in the entity’s promotional material.
- It is located more than 35 miles from the main campus of the hospital.

Q. Who decides whether an entity is a hospital clinic or physician office?

A. The CMS decides after a hospital applies for the entity to be considered a provider-based clinic.

Requirements for a hospital outpatient clinic

A site must meet the following criteria to be designated a hospital outpatient clinic:

- **Licensure:** The provider-based entity (“entity”) must operate under the same license as the main provider, except in states that require a separate license or do not permit a single license.

- **Ownership/control:** The entity must be entirely owned by the main provider (primarily a “hospital”). An entity operated under a management contract is considered provider-based if it meets specific criteria regarding staff employment and day-to-day operational control. The hospital itself must hold the contract. The entity must be operated by the hospital’s own governing board and be subject to the hospital’s organizational and operating policies.

- **Administration and supervision:** Billing, payroll, purchasing, human resources, and so on must be fully integrated between the entity and hospital.

- **Clinical services:** The hospital’s clinical services must feature:

1. Complete integration with the hospital.
2. Professional staff with admitting privileges at the hospital.
3. A medical director who reports to the hospital’s medical director.
4. Utilization review and quality assurance policies governed by the hospital.
5. A medical record system that is fully integrated with the hospital’s.
6. A policy that patients can be referred to the main provider.

- **Financial integration:** Costs associated with the entity should be reported as a separate cost center of the hospital and its financial state-

ments should be identified in the hospital’s trial balance sheet.

- **Public awareness:** The entity must be represented to the public as part of the hospital.

- **Geographic location:** BIPA requires an entity to be located not more than 35 miles from the main campus of the hospital. The final CMS regulation had required that the entity and hospital serve the same patient population from the same service area using the so-called 75/75 test. Under this test, the entity would be deemed to serve the same population if, during the previous 12-month period, at least 75 percent of the entity’s patients also received care at the hospital. BIPA overrides the CMS rule.

- **Two-year grandfathering:** BIPA also provided that any entity treated as a hospital-based entity on October 1, 2000, would continue to be treated as such until October 1, 2002. However, such “grandfather status” does not exempt these entities from the EMTALA responsibilities or the requirement to provide written notices to Medicare beneficiaries of coinsurance liability.

- **Temporary treatment as hospital-based:** Finally, BIPA provided that an entity was deemed to be hospital-based at the time a hospital made application for such a status. The provision is applicable to requests for hospital-based determination made between October 1, 2000, and October 1, 2002. This allows for Medicare reimbursement as if the entity is a hospital-based entity. If, after consideration, CMS concludes the entity is not, in fact, eligible for hospital-based status, CMS may seek recovery of any Medicare overpayments made during the determination-processing period.

Examples of differences in payment

Following are examples of the differences in Medicare payment and beneficiary copayment in a physician's office and in a hospital clinic. Before doing a similar analysis, be sure to get current figures from your hospital for two reasons. New figures for the remainder of 2002 should have come out shortly before this article is published. Where a hospital has a copayment higher than normal, they may elect to lower the copayment to any amount that is at or above the normal amount. Normally, Medicare pays 80 percent of the payment amount and the coinsurance is 20 percent of the payment amount.

Example: 99213 Office/outpatient visit, established

<u>Payment type</u>	<u>In physician's office</u>			<u>In hospital clinic</u>		
	<u>Total</u>	<u>From Medicare</u>	<u>From patient</u>	<u>Total</u>	<u>From Medicare</u>	<u>From patient</u>
Physician fee schedule	\$50.32	\$40.26	\$10.06	\$34.03	\$27.22	\$6.81
Outpatient prospective payment system	0.00	0.00	0.00	48.36	38.69	9.67
Total	\$50.32	\$40.26	\$10.06	\$82.39	\$65.91	\$16.48

Example: 19101 Biopsy of breast; open, incisional

<u>Payment type</u>	<u>In physician's office</u>			<u>In hospital clinic</u>		
	<u>Total</u>	<u>From Medicare</u>	<u>From patient</u>	<u>Total</u>	<u>From Medicare</u>	<u>From patient</u>
Physician fee schedule	\$313.12	\$250.50	\$62.62	\$193.67	\$154.94	\$38.73
Outpatient prospective payment system	0.00	0.00	0.00	712.66	408.92	303.74
Total	\$313.12	\$250.50	\$62.62	\$906.33	\$563.86	\$342.47

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Q. Is the Medicare physician payment the same if the site of service is a clinic and not a physician office?

A. No. If the entity is a hospital-based clinic, the physician is paid from the physician fee schedule according to the in-facility rate rather than the higher in-office (or non-facility) rate.

Q. How does reimbursement to the hospital change if the site of service is a clinic?

A. If the entity is considered a physician office, the hospital does not receive any payment from Medicare for hospital services. In this case, if the hospital owns the physician practice, the hospital would be paid based on the physician fee schedule. On the other hand, if the entity is a hospital clinic, the hospital would be paid under the outpatient PPS, and the physician payment would be based on the physician fee schedule rate for in-facility services.

Of course, if the physician owns the practice, he or she would be paid based on the Medicare physician fee schedule (using the in-office or non-facility rate).

ity rate), and the physician would be paying a fair market rent to the hospital under a written lease agreement.

Q. Does it matter to patients whether the site of service is a hospital clinic or physician office?

A. Yes. The site of service affects the amount of coinsurance owed by the beneficiary. The examples on page 10 compare how the physician office and clinic situations are treated under Medicare for two different services. It is also important to note that each private insurance plan has its own rules governing the amounts paid to the physician and the amount of the payment that the beneficiary owes as coinsurance. As with Medicare, these amounts usually will vary depending on whether the site of service is a clinic or physician office.

Q. Are there any potential pitfalls under the anti-kickback laws when a physician's practice is purchased and becomes a provider-based clinic?

A. There is a safe harbor under the Medicare and Medicaid anti-kickback laws for sales of physician practices that, in essence, requires that the purchase price and any subsequent compensation by the hospital be at fair market value (not taking into account any referrals). However, surgeons should bear in mind that they should pay a commercially reasonable rent for office space provided by the hospital once the practice has been purchased. Free space or an abnormally low rent may be viewed as "remuneration" to encourage the physician to refer patients to the hospital.

Q. Does a Medicare determination that the entity is a hospital clinic and not

a physician office also apply to non-Medicare patients?

A. Yes. The hospital must decide how it intends to treat a particular site and apply this determination to all patients, regardless of their source of payment. Physicians also must know when the site is a clinic so they can indicate the site of service accurately on the bill. If the entity is a hospital outpatient clinic, then the surgeon must designate the site of service as the hospital outpatient department on all bills, not just claims for Medicare patients.

Q. Are physicians affected in other ways if a site becomes a provider-based clinic of a hospital?

A. If the hospital has an emergency department (ED), the provider-based rules stipulate that EMTALA (the Emergency Treatment and Active Labor Act)—which requires screening and stabilization of individuals presenting with an emergency medical condition—will apply to the hospital's provider-based clinics as well as its main campus. This does not necessarily mean that these clinics must function as EDs, but it does mean that the EMTALA requirements may be triggered when an individual presents at a clinic and that the clinic and the hospital must have arrangements for ensuring screening and stabilization requirements are met promptly. Provider-based status also triggers a requirement that Medicare beneficiaries be given written notice of their coinsurance liabilities.

Q. When do the provider-based rules take effect?

A. The rules became effective for hospital cost-reporting periods beginning January 10, 2001. BIPA, however, made significant changes

Factors to consider before your practice becomes an outpatient clinic

by Jean Harris, Associate Director,
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- **You will become an employee of the hospital if your practice becomes a hospital outpatient clinic.** The hospital would have full decision-making power over your practice, including what procedures you provide and hiring (and firing) of staff. There will be renegotiations so that, eventually, practically everything may change.

- **The hospital may want access to more cash flow.** At a minimum, the hospital will want money for the expenses it incurs in relationship to running your practice. It will also want you to pay a commercially reasonable amount for rent (regardless of whether your practice becomes an outpatient clinic or retains its physician office status after the sale).

- **The hospital may be seeking a part of additional reimbursement.** Medicare reimbursement rates are more generous for the hospital department and the same is probably true for other payors as well.

- **There will probably be a dramatic increase in Medicare copayment liabilities.** You could certainly disadvantage your patients financially and could even lose patient referrals. Figure the increase by using the examples on page 12 as a guide, but, because each hospital's copayments are unique, be sure to get actual amounts from your hospital.

- **You will have new regulatory obligations.** These include making arrangements for complying with EMTALA (which can be a substantial burden) and giving Medicare patients a written notification of coinsurance liabilities.

- **Be especially careful about coding arrangements.** You are liable for what is billed in your name.

to these rules as described in the summary of the regulation on page 11.

Q. How could these rules be simplified for physicians?

A. One area to pursue for regulatory relief is the application of EMTALA requirements. Hospital-based clinics, especially those not located on the hospital's main campus and near the emergency room, should not be held to the same standards as the main hospital. Treating hospital-based entities as the equivalent of the emergency department for EMTALA purposes will do a disservice to individuals needing emergency services and will place unreasonable and legally unsupported expectations on those facilities.

The better approach is to interpret the statute as requiring hospitals with emergency departments to have policies and procedures to ensure that a person who presents to the hospital requesting emergency services is provided a medical screening exam and, if needed, stabilization or an appropriate transfer. □

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ATLS® training:

A novel approach

by Christopher B. Weldon, MD, PhD, Eric Silberfein, Peggy L. Chehardy, EdD, and Norman E. McSwain, Jr., MD, FACS

It's 2:32 am on a Tuesday, which is Tulane admitting day and emergency department procedure day in the major trauma resuscitation room of the Medical Center of Louisiana, New Orleans, LA, Charity Hospital Campus. Background noise and chatter stops as the trauma pagers sound off in unison, heralding the beginning of a trauma code. Personnel spanning all 19 floors and medical fields in the hospital arrive to care for the injured patients. New Orleans Health Department Emergency Medical Service personnel, under the direction of a rotating third-year Louisiana State University (LSU) emergency medicine resident, deliver two patients who sustained multiple gunshot wounds while driving their automobile. The unrestrained driver is a young male with a gunshot wound to his left chest and facial trauma. The second victim is the unrestrained, front-seat passenger, who has sustained multiple gunshot wounds to his lower abdomen.

Under the direction of the Tulane University School of Medicine surgical trauma staff, these patients are methodically and systematically cared for using the principles outlined in the Advanced Trauma Life Support® (ATLS®) course adminis-

tered by the American College of Surgeons' Committee on Trauma (COT). The LSU emergency room staff and two fourth-year LSU trauma residents, with the assistance of respiratory personnel, are at the heads of these patients' beds, controlling their airways. A Tulane chief surgical resident, third-year surgical resident, second-year surgical resident, two surgical interns, and rotating emergency department interns (LSU surgical intern and an LSU emergency medicine intern), in conjunction with seven emergency department nurses and four medical students, care for these patients.

Although the room is hectic and noisy, the trauma codes flow with calculating precision, minimal confrontations, and few directives delivered. Within minutes, the patients' life-threatening injuries are identified, treatment initiatives are rendered, and the patients are whisked away to the operating rooms. At 2:39 am, the custodial staff begins scouring the room and disposing of the trash, the physicians tend to the paperwork and medical interventions, and the nursing staff quickly reassemble the room for the next trauma code.

Background on ATLS

For the nation and the world, the systematic approach to the implementation of trauma resuscitation began in 1978, in Auburn, NE.¹⁻³ Paul E. Collicott, MD, FACS, implemented and tested the pilot program of the ATLS course after almost two years of development and research. The inception of this program began some two years earlier when a colleague of Dr. Collicott's, James Styner, MD, FACS, and his family were severely injured in an airplane crash.^{3,4} Specifically, the impetus for the creation of this course, which is devoted to the proper education of physicians in the evaluation and treatment of trauma victims, stemmed from the inadequate care that Dr. Styner and his family received in a rural hospital emergency department.

The ATLS course was modeled on the Advanced Cardiac Life Support (ACLS) program that had just taken root in 1976.^{3,5} The emphasis of the ATLS initiative was to help emergency personnel recognize and maximize the "golden hour" of resuscitation in the evaluation and treatment of trauma patients. This goal has remained constant for the last quarter century.

From this early, Midwestern beginning, the course was adopted officially one year later by the COT over the weekend festivities of the annual Oklahoma-Nebraska football conflict.³ Over the next decade, the course spread beyond the confines of Nebraska. In fact, it has now been adopted by more than 30 countries and had 350,000 graduates from 21,000 courses as of July 2001.



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Charity Hospital's approach

ATLS training for Charity Hospital residents was initiated through the Department of Surgery at Tulane University School of Medicine. Trauma codes are conducted more than 4,500 times each year at Charity Hospital, and the ATLS training regimen proves to be the one constant that three residency programs from two universities use in the delivery of trauma care. ATLS provides a simple, universal, and reproducible treatment algorithm, and, most importantly, it provides a common language for all participants, regardless of experience, training, or medical discipline.⁶

Although the collaboration of multiple residency programs from both a private institution and a public entity in the delivery of medical care in a single hospital is not unique, the ATLS training regimen employed in the Charity Hospital system is indeed novel. Our ATLS educational mission began over 15 years ago.

As the importance of ATLS was embraced nationally and internationally, the impact at Charity Hospital also grew. Charity serves as the primary trauma center for Orleans and St. Bernard Parishes—representing a population of over 525,000—in the greater New Orleans metropolitan area. The provision of health care at Charity Hospital has been administered jointly by Tulane and LSU for more than 70 years.⁷ Admitting privileges are alternated on a daily basis between Tulane and LSU. Consequently, the concept of Tulane ("T") and LSU ("L") days arose to signify which institution and its programs were "on-call" for a given day.

The trauma service consists of a staff trauma surgeon, a chief surgical resident, a third-year surgical resident, two surgical interns, and two medical students from either LSU or Tulane, while the LSU emergency room program staffs the Charity Hospital emergency department with an ER staff physician, two senior ER residents, and several rotating ER interns. Procedures performed in trauma codes are also split between the ER and the surgical unit (SU) services on alternating days, as well. Therefore, the concept of "E" days (for an ER-performed procedural day) and "S" days (for an SU-performed procedural day) is also in effect. Ultimately, at least 10 physicians, spanning all levels of training and experience, are drawn from three residency programs to deliver trauma care

as mandated by the protocols set forth by ATLS. All of these physicians completed ATLS together—at both the provider and the instructor level—in the same classroom, with the same instructors and educator.

The ATLS educational program is a core component of the Tulane Life Support Training Program within the Center for Clinical Effectiveness and Prevention at the Tulane University Health Sciences Center (TU). The director has a doctorate in education and has amassed at least 16 years of experience in the coordination of the ATLS program at the local, state, and national levels. Two full-time employees are responsible for the clerical and scheduling duties required in the delivery of the ATLS courses. The ATLS courses require a minimum of 2,000 square feet of space, and the courses are taught on weekends to accommodate both students and instructors. Approximately 15 “double” provider and reverification courses and four instructor courses are conducted each academic year. Traditionally, these courses are resident-run under the guidance of staff physicians, and the continued success and interest in these programs is a direct outgrowth of the commitment shown to the ATLS initiative by present resident and staff members. In fact, all three programs mandate that incoming residents must be ATLS providers before they may formally begin a residency program. As a corollary, Charity Hospital nursing administrators, through the direction of the COT state chairman’s office, mandate that all ER nursing personnel audit the ATLS course. Additionally, all second-year residents are expected to become ATLS instructors and to participate in the future courses. Finally, every two to three years, one senior resident from the TU-SU and one from LSU-SU are further selected and nominated by the staff of each program to earn ATLS state-faculty status.

Effectiveness of approach

The ability and success of this combined educational effort is witnessed when the data over nine years are analyzed and reviewed. From January 1992 to December 2000, a total of 99 ATLS provider courses were conducted at our facility. Nearly 1,700 individuals took the ATLS provider course with a successful passing rate of just under 98 percent, which is slightly higher than those in other

published series.^{3,8} The mean score for these students on the written exam was 86.75 percent. Of those students who reported the medical discipline they practiced, 40 percent were emergency medicine physicians, 29 percent were surgeons, and a surprising 31 percent were from other medical specialties. The proportion of surgeons (29% v. 25%) and emergency medicine physicians (40% v. 12%) participating in our series were higher than reported in another published series,³ and 42 percent of our students were residents. Although the majority of our participants came from Louisiana, some 26 percent of those physicians who attended the course were from outside the state, which is also higher than in another reported series.⁸

Upon analyzing the data from the ATLS instructor courses given over the same time period, 172 instructors were trained, with resident physicians being the overwhelmingly majority (75%) of the instructor candidates. Surgeons represented 55 percent of those physicians taking the instructor course, with emergency medicine physicians accounting for 26 percent, and all other medical disciplines accounting for just 18 percent. The percentage of surgeons and emergency medicine physicians taking the instructor course is higher than indicated in another published series.³ Out-of-state residents accounted for only 10 percent of the ATLS instructors trained at our institution.

A final cohort of data that was analyzed centers on individuals taking the student reverification portion of the ATLS course from January 1993 to December 2000. A total of 126 students took this portion of the course, and the overwhelm-

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ing majority (62%) were emergency medicine physicians, while surgeons comprised only 12 percent of the sample reviewed. These data corroborate earlier studies documenting the dearth of participation among practicing surgeons in ATLS courses and certification.^{8,9} Beyond these observations, however, more fundamental lessons concerning the benefits of this uniquely administered ATLS endeavor are evident from a student, resident, and staff physician perspective.

Benefits

Multiple studies have documented the educational value of the ATLS course, especially with regard to the clinical implementation of trauma care.^{6,10-13} In addition to these previously published benefits, students who participated in our ATLS educational format not only had the ability to be trained by physicians working in a Level I trauma center, but the instruction spanned the knowledge and research efforts of three departments from two universities. Besides the plethora of clinical knowledge and expertise disseminated during these courses, discussions spanning a multitude of related topics are routinely conducted, including prehospital trauma life support information, the establishment of trauma systems, and the evaluation of medico-legal issues. One other key component is the wealth of educational experience that the instructors possess secondary to their early and active involvement in the delivery of these courses. Hence, not only do the students get exposure to instructors possessing the clinical acumen necessary to provide a consistently high level of

knowledge, but they also have the advantage of being taught by instructors with a great deal of teaching experience. The students, however, are far from the only individuals who reap a great deal from the opportunity sewn by this multidisciplinary ATLS program.

Staff physicians from all three residencies have commented on the merits of this program, especially from the perspective of early trauma training for residents: an introduction for them into a discipline that most will practice in some form or other for the remainder of their careers. These views correlate with previously published experiences.^{6,9} Early exposure to the discipline of trauma care will further provide an impetus for residents to formally choose it as a career or to continue close interactions with ATLS programs after the completion of residency training.

Another benefit commonly mentioned is the opportunity for residents to interact with staff, and these situations lead to further and more substantive interactions as the resident progresses in training. Interaction with fellow staff members within the system and colleagues working at outlying hospitals who simply take the ATLS course cement relationships that make for a productive and efficient workplace in the hospital setting when trauma codes arrive or the transfer of patients is required. Finally, and most importantly, the need to serve as instructors and role models for residents-in-training mandates that staff physicians stay at the forefront of breaking concepts in trauma care.

However, the group that receives the most from this combined educational approach to ATLS is the residents.^{10,11,13} From an educational perspective, trauma is an integral component of resident training because surgeons and ER physicians spend at least 20 percent of their training in trauma at Charity Hospital. Therefore, the expectation of active participation in the ATLS program provides an excellent knowledge base from which trauma education can begin and mature. With continuing education as ATLS instructors, the basal fund of knowledge provided by the ATLS provider course becomes solidified through the participation in the instructor courses.¹⁴

Another benefit of this ATLS program is the constant interaction of the three residency programs in a setting removed from the hospital, because



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this allows relationships to develop that will assist in the delivery of patient care. The residents train, teach, and work together often from the beginning, and intellectual quarrels are minimized secondary to the common language provided by their ATLS training.

However, the greatest advantage of this collective educational arrangement for the residents is the opportunity to acquire the teaching and verbal skills espoused in the ATLS instructor course. The staff serendipitously discovered that the residents were more confident and able speakers, and this skill was honed through years of experience serving as ATLS instructors.^{10, 11, 13}

Approach in action

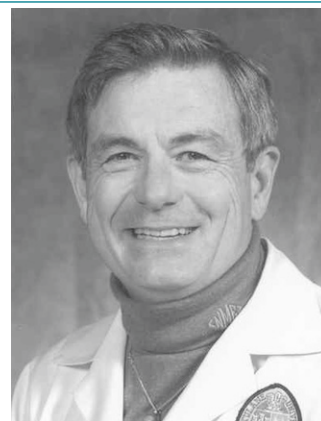
It's 2:52 am on a Tuesday, "T"/"E" day in the major trauma resuscitation room of Charity Hospital. Background noise and chatter stops as the trauma pagers sound off in unison, heralding the beginning of a trauma code that will be conducted through the protocols outlined in the ATLS course. Physicians and nurses all trained together in these principles will deliver the necessary medical care as dictated by ATLS protocols.

After 25 years, ATLS continues to be the cornerstone in the delivery of trauma care, and its future success will depend on the continued involvement of surgeons. Through our novel ATLS educational effort, we believe that early and active involvement of residents and staff from several residency programs and institutions assist in the development of all physicians, regardless of level of training. Active participation by these programs and institutions also ensures the best educational front is provided to all physicians and nurses who participate in our ATLS courses, be it as students or as instructors. 

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Dr. McSwain is National Faculty for ATLS and was a member of the first ATLS Subcommittee for the Committee on Trauma.





Patient safety update

*Office-based surgery
regulation
expands*

by Jon Sutton,
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In February 2001, the *Bulletin* featured an article titled “Office-based surgery regulation: Improving patient safety and quality care.” This article reviewed the issue of patient safety as it relates to office surgery regulation, discussed statutory and regulatory requirements in five states (**California, Florida, New Jersey, Rhode Island, and Texas**), and compared these states’ requirements with the College’s *Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery*.

Since that article was published, five states have taken action to address the issue of office surgery regulation. **Illinois** issued rules for the supervision of the administration of anesthesia, and **Connecticut** passed legislation pertaining to accreditation of physician offices where anesthesia is administered. **Mississippi** issued rules governing office-based surgical procedures, and **New York** issued guidelines for office surgery (which were recently declared null and void by the New York State Supreme Court). Finally, the **South Carolina** Medical Association developed guidelines for office surgery and provided them to the state board of medical examiners, which adopted them in October 2001.

This article examines in greater detail the actions these states have taken. It is important that surgeons in these states comply with the law and are aware of recommended guidelines. For surgeons in states in which office surgery is not regulated, it is helpful to understand that regulation may be forthcoming.

State activity

At least 24 states have considered some form of legislation, regulation, or guidelines to address the issue of office-based surgery in the last several years. Interest increased dramatically in 2000, when 96 deaths were reported nationwide, with 18 deaths occurring in Florida over the last two years.¹ Common elements of many of these proposals (including those passed/adopted) have included requirements that: (1) physicians have hospital privileges to perform the same procedure in the office or be accredited/credentialed by inpatient facilities or some recognized entity; (2) physician offices be accredited by one of the three major ambulatory surgery accreditation organi-

zations or the Medicare program; (3) types of surgical procedures and anesthesia administered in the office setting be based on the training and qualifications of the surgeon and on the American Society of Anesthesiologist’s (ASA’s) *Guidelines for Office-Based Anesthesia*; and (4) for other than local anesthesia, the surgeon be certified in advanced cardiac life support (ACLS), with other personnel at least certified in basic life support. Each state, however, has tailored its approach to meet local needs and concerns, and, as a result, the requirements range in scope from very comprehensive, as in **Florida**, to minimally restrictive, as in **Connecticut** and **Illinois**.

Connecticut, Illinois, Mississippi, New York, and South Carolina have recently taken action that reflects various approaches adopted by other states, such as **California, Florida, New Jersey, Rhode Island, and Texas**. Details about the actions taken in these states follow.

Connecticut

Legislation to regulate office surgery in Connecticut went into effect on July 1, 2001. Any office or unlicensed facility operated by a licensed health care practitioner or practitioner group at which moderate sedation/analgesia, deep sedation/analgesia or general anesthesia is administered must be accredited. Four accrediting bodies are recognized by the state: (1) the Medicare program; (2) the Accreditation Association for Ambulatory Health Care (AAAHC); (3) the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF); and (4) the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Accreditation must be obtained by January 1, 2003, or within 18 months of the date on which moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia is first administered. Evidence of this accreditation must be kept at the office or facility. Failure to comply could result in disciplinary action against the surgeon’s medical license.²

Illinois

The Illinois Department of Professional Regulation adopted rules on March 15, 2001, relat-

ing to the delivery of anesthesia services by a Certified Registered Nurse Anesthetist (CRNA). In a physician's office, a CRNA may only provide anesthesia services if the physician has training and experience in the delivery of anesthesia services to patients. This training and experience may include one of the following:

1. Maintenance of clinical privileges to administer anesthesia services in a hospital or a licensed ambulatory surgical treatment center.
2. Completion of continuing medical education (CME): eight hours of CME within each three-year license renewal for conscious sedation only; and 34 hours of CME within each three-year license renewal for deep sedation, regional anesthesia, and/or general anesthesia. The CME program must be conducted by a university, professional association, or hospital as defined by the Illinois administrative code.

In addition, the physician and the CRNA must maintain current ACLS certification.³

Mississippi

The Mississippi State Board of Medical Licensure issued a rule, effective September 1, 2001, regulating office-based surgical procedures. The rule divides surgical procedures into three levels and sets requirements that must be met for a physician to perform each level in an office. Any licensed physician performing a surgical procedure in the office must register with the state board, maintain logs of Level II and Level III surgical procedures, be certified in ACLS, comply with the Occupational Safety and Health Administration's (OSHA's) sterilization standards, and report to the state board any adverse incident. In addition, the rule recommends, but does not require, compliance with ASA's *Guidelines for Office-Based Anesthesia* for all Level III surgical procedures.⁴

New York

The New York State Department of Health issued, in December 2000, a report based on the work of its Committee on Quality Assurance in Office-Based Surgery. Titled *Clinical Guidelines for Office-Based Surgery*, the report was the result of two years of reviewing existing guidelines

and meeting with accrediting bodies and health care professionals.

However, the New York State Supreme Court on November 25, 2001, declared the guidelines to be null and void and issued a permanent injunction prohibiting the Department of Health from publishing, distributing, or enforcing the guidelines.

South Carolina

The South Carolina Medical Association (SCMA) Task Force on Office-Based Surgery developed a proposal for office surgery guidelines, which was approved by the SCMA House of Delegates in April 2001 and then adopted by the State Board of Medical Examiners. The guidelines describe the essential components an office-based surgical practice should address, including recommendations for facilities, anesthesia, pre- and postsurgical evaluations, equipment, credentialing, emergency protocols, and reporting of adverse outcomes.

Physician offices are classified according to the complexity of anesthesia and surgical care provided. The office classifications include three levels: (A) Level I—minor procedures performed under topical or local anesthesia; (B) Level II—procedures involving minimal or moderate sedation/analgesia and in which there is only a small risk of surgical or anesthetic complications; and (C) Level III—higher-risk procedures requiring the use of deep sedation/analgesia, general anesthesia, or major conduction blockade. The recommendations pertaining to the delivery of anesthesia would require that a licensed, qualified, and competent practitioner administer anesthesia, and any individual administering conscious sedation and/or monitoring the patient would be prohibited from assisting the surgeon in performing the procedure. Supervision of the sedation/analgesia component of the procedure must be by a physician, and he or she must be physically present during the procedure.

The guidelines recommend emergency equipment and transfer plans for all three office classifications. The surgeon should have an appropriate level of training and experience for the specific procedure performed and be ACLS-cer-

tified. In the case of Level II and III offices, at least one other assistant should be ACLS-certified, or a qualified anesthetic provider should be available. Criteria to be considered when determining the level of training and experience should include: (1) procedure-specific education, training, experience, and successful evaluation; (2) American Board of Medical Specialties or equivalent board certification or eligibility; (3) participation in peer and quality review; (4) CME; (5) malpractice coverage; (6) active hospital and/or ambulatory surgical center privileges; and (7) adherence to professional society standards.

Level II or III offices would be required to be accredited by the AAAASF, the AAAHC, or the JCAHO.⁵

What surgeons can do

Although at least nine states (**California, Connecticut, Florida, Illinois, Mississippi, New Jersey, Rhode Island, South Carolina, and Texas**) now regulate or have guidelines relating to office-based surgery or the use of anesthesia in the physician's office, 41 states still lack regulation. Some of these states already are starting to act. For example, three states—**Kentucky, New York, and Virginia**—by press time had introduced legislation dealing with office surgery, and the Kansas Medical Society was in the process of developing guidelines. Surgeons and chapters in these states need to be alert to potential attempts by state agencies or legislators to develop regulations or guidelines. To do this, the College recommends that chapters and surgeons:

1. *Monitor the issues and activities of the state's medical board.* If rules are to be issued or guidelines to be developed in a state, they are likely to come from the medical board. Chapters should be aware of proposals to regulate office surgery and ask to be placed on the medical board's mailing list to receive copies of meeting agendas. To obtain contact information for a state's medical board, visit the Federation of State Medical Boards Web site at <http://www.fsmb.org>, and select State Medical Board Info from the menu on the left side of the page.

2. Provide copies of the ACS *Guidelines for*

Resources and guidelines

- American College of Surgeons *Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery* may be ordered online at <http://www.facs.org/commerce/guidelines.html>.

- American Society of Anesthesiologists *Guidelines for Office-Based Anesthesia* is available at <http://www.asahq.org/Standards/12.htm>; and *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists* is available at <http://www.asahq.org/practice/sedation/sedation.html>.

- American Society of Plastic Surgeons *Patient Safety Model Legislation* is available at http://www.plasticsurgery.org/psf/psfhome/myprac/Patient_Safety_Model_Legislation.pdf (this page is for members only).

- Information on office accreditation can be found at:

- American Association for Accreditation of Ambulatory Surgery Facilities, Inc.: <http://www.aaaasf.org>.

- Accreditation Association for Ambulatory Health Care, Inc.: <http://www.aaahc.org>.

- Joint Commission on Accreditation of Healthcare Organizations: <http://www.jcaho.org>.

Optimal Ambulatory Surgical Care and Office-based Surgery to medical boards or legislators considering regulation of office-based surgery. When the *Guidelines* were updated in 2000, they were distributed to all state medical boards. The book could have easily been misplaced, however, so it is important to make sure that those who may develop rules, guidelines, or legislation pertaining to this issue have a copy of the *Guidelines*. Copies may be ordered online through the ACS Web site at <http://www.facs.org/commerce/guidelines.html>.

3. *Use the expertise of College officials if rules, guidelines, or bills are being developed to regulate office-based surgery.* The members of the ACS Board of Governors Committee on Ambulatory Surgical Care are available as a resource to talk with chapters or surgeons involved in the process of developing office-based surgery guidelines or rules. This Committee developed the *ACS Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery*. To contact one of the committee's members, use the information posted on its Web site at www.facs.org/about/governors/ambulatory.html.

4. *Monitor the activities of the state medical association in this area.* Many state medical societies have not adopted policy on the issue of regulation of office-based surgery. However, these societies may sponsor an interspecialty council or council of specialty societies, which offers a forum for specialty societies to bring issues to the table. In addition, a state medical association might be approached by a medical board or other governmental entity to develop guidelines for office-based surgery, and it is important for the surgical community to have representation on any committee formed to do this.

Chapters or surgeons seeking assistance with this issue are encouraged to contact Jon Sutton, State Affairs Associate, in the Chicago office of the Division of Advocacy and Health Policy. He may be reached by calling 312/202-5000, or via e-mail at jsutton@facs.org. He also can provide copies of the items referenced in this article. □

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3. *Nursing and Advanced Practice Nursing Act—Advanced Practice Nurse*. 68 Illinois Administrative Code 1305: 24 Ill. Reg. 14159, March 15, 2001.
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Ten specialty boards report accomplishments and plans:

Part II

Each year, the 10 surgical specialties recognized by the American Board of Medical Specialties report to the ACS Board of Regents. Their reports are published in a condensed form in the *Bulletin* to keep Fellows abreast of any changes in the procedures of the various boards. The American College of Surgeons makes nominations to the following six boards: The American Board of Colon and Rectal Surgery, the American Board of Neurological Surgery, the American Board of Plastic Surgery, the American Board of Surgery, the American Board of Thoracic Surgery, and the American Board of Urology.

This issue of the *Bulletin* features the reports of the American Board of Colon and Rectal Surgery, the American Board of Obstetrics and Gynecology, American Board of Plastic Surgery, the American Board of Surgery, and the American Board of Thoracic Surgery.

The March issue of the *Bulletin* contained the reports of the American Board of Neurological Surgery, the American Board of Ophthalmology, the American Board of Orthopaedic Surgery, the American Board of Otolaryngology, and the American Board of Urology.

The American Board of Colon and Rectal Surgery

by Herand Abcarian, MD, FACS, Chicago, IL

Past and future meetings

The American Board of Colon and Rectal Surgery (ABCRS) held its most recent annual meeting September 30, 2001, and its most recent interim meeting March 25, 2001, in Chicago, IL. Coinciding with these meetings are the oral and written examinations, respectively. Future meetings and exams will be held in Chicago through 2004. Upcoming interim meetings and written examinations will take place March 22-23, 2003, and March 20-21, 2004. Future annual meetings and oral exams are set for September 21-23, 2002, September 20-22, 2003, and October 1-3, 2004.

Officers and members of the board

The ABCRS is composed of 12 members. Nominations to fill vacancies are made by the board and five other sponsoring organizations: the American Society of Colon & Rectal Surgeons (ASCRS), the American College of Surgeons, the American Medical Association, the Association of Program Directors for Colon and Rectal Surgery, and the American Board of Surgery. Board members normally serve two four-year terms—a total of eight years.

Current officers are: Ian C. Lavery, MD, FACS, president; James W. Fleshman, MD, FACS, vice-president; and Herand Abcarian, MD, FACS, executive director (at pleasure of the board). Current members of the board are: Richard P. Billingham, MD, FACS; Robert D. Fry, MD, FACS; Terry C. Hicks, MD, FACS; Vendie H. Hooks, MD, FACS; Donald L. Kaminski, MD, FACS; Robert D. Madoff, MD, FACS; John P. Roe, MD, FACS; Alan G. Thorson, MD, FACS; and Bruce G. Wolff, MD, FACS.

Associate examiners

The board maintains a slate of associate examiners whose terms rotate at different intervals. Currently, there are 16 associate examiners: P. Sue Beckwith, MD, FACS; W. Donald Buie, MD, FACS; Marcus J. Burnstein, MD, FACS; Jose R. Cintron, MD, FACS; Richard M. Devine, MD, FACS; Frank J. Harford, MD, FACS; Neil H. Hyman, MD, FACS;

Ann C. Lowry, MD, FACS; Frank G. Opelka, MD, FACS; Bruce A. Orkin, MD, FACS; Jan Rakinic, MD, FACS; Thomas E. Read, MD, FACS; Theodore J. Saclarides, MD, FACS; Clifford L. Simmang, MD, FACS; Judith L. Trudel, MD, FACS; and Richard L. Whelan, MD, FACS.

Examination committee activities

The ABCRS examination committee, under the direction of James W. Fleshman, MD, FACS, is focusing its attention on standardizing the oral examination process. The committee's goal is to change the oral examination process from one that tests candidates' recall abilities to one that tests their cognitive skills. The committee plans to accomplish this goal by presenting questions related to patient scenarios with specific key features built into each case. All oral examiners will test on the same material and be instructed to gather responses in key elements from each candidate. The scoring process also will change to become more fair and more useful in identifying areas or categories in which candidates fail.

The ABCRS and the ASCRS cosponsored a key feature question writing workshop Thursday, September 27, 2001. It was moderated by Judith L. Trudel, MD, and Richard L. Nelson, MD, FACS. Because the board is incorporating key feature questions into its certification/recertification testing process, its goal was to familiarize colon and rectal surgeons with this new concept, and to present an instructional course on the fundamentals of constructing key feature questions. There were approximately 40 participants, including current and former board members, associate examiners, program directors, and ASCRS self-assessment committee members.

Retraining program

At the September 2000 meeting, the board approved a policy to establish an abbreviated educational retraining program for candidates who were unable to achieve certification after exhausting all available opportunities within the prescribed seven-year period. The current reentry mechanism

Table 1
ABCRS recertification performance: 1998-2001

<u>Year</u>	<u>Participants</u>	<u>Passed</u>	<u>Percent</u>	<u>Failed</u>	<u>Percent</u>	<u>Maximum</u>	<u>Minimum</u>	<u>Average</u>
2001	24	23	96%	1	4%	90%	69%	81%
2000	16	13	81	3	19	90	59	80
1999	68	62	91	6	9	94	61	82
1998	46	44	96	2	4	93	57	81
Total	154	142	92%	12	8%	Passing score: 70%		

Table 2
ABCRS examination results

	Written exam - March 24, 2001 (67 candidates)					Oral exam - September 29, 2001 (68 candidates)				
	<u>No.</u>	<u>Fail rates</u>	<u>Percent</u>	<u>Pass rates</u>	<u>Percent</u>	<u>No.</u>	<u>Fail rates</u>	<u>Percent</u>	<u>Pass rates</u>	<u>Percent</u>
Total candidates	67	11/67	16%	56/67	84%	68	15/68	22%	53/68	78%
First-time takers	58	6/58	10	52/58	90	58	14/58	24	44/58	76
Repeat candidates	9	5/9	56	4/9	44	10	1/10	10	9/10	90

requires candidates to complete a full one-year colon and rectal residency program approved by the Accreditation Council on Graduate Medical Education (ACGME), followed by submission of a new application for examination. The interval for the remedial training program is four months and must be conducted in a full-time ACGME-approved colon and rectal surgery residency program. The program director will serve as the preceptor and will assign duties and responsibilities to the trainee with assistance from the faculty. All such training must be approved in advance by the board.

At its March 2001 meeting, "Guidelines for Additional Training" were approved and circulated to program directors. A poll was conducted to determine how many programs would be able to participate. So far, a number of programs have agreed

to enroll. Their input will be essential to the process because, ultimately, program directors will have to help train, confirm, and document whether the trainee successfully completed the prescribed curriculum. The guidelines for training are available from the ABCRS administrative office.

Policy on operative performance

For several years, the ABCRS has maintained an operative database in which the numbers of cases from graduating residents are entered into 17 grouped categories. A statistical formula is used to establish the minimal number of cases that should be performed in each category. A number of reports and tables are generated from the data and provided to program directors to assist them in evaluating their residents' operative performance. One of the reports that is ex-

Table 3
ABCRS diplomates geographic/gender distribution

<u>Total current diplomates</u>	<u>Male</u>	<u>Percent</u>	<u>Female</u>	<u>Percent</u>	<u>All</u>	<u>Percent</u>
Active U.S.	953	74.80%	81	6.36%	1,034	81.16%
Active international	59	4.63	2	0.16	61	4.79
Retired U.S.	168	13.19	2	0.16	170	13.34
Retired international	4	0.31	0	0.00	4	0.31
Status/address unknown	5	0.39	0	0.00	5	0.39
Total	1,189	93.33%	85	6.67%	1,274	100%

*This figure excludes diplomates who are deceased.

tremely useful is a "Category Deficiency Table." It tracks the operative performance of each resident within the 17 categories and "flags" those with shortages in five or more categories. This table has been generated for the last four years (1997-2000) and has been invaluable in assisting the board with its credentialing process. The information has also shown that the average numbers in each category do not change significantly from year to year.

At the September 2000 meeting, a decision was made to adopt a standards policy based on the operative data findings in the "Category Deficiency Table." It states:

Minimum numbers representing a reasonable range within each of the 17 operative categories have been established. Accordingly, residents displaying insufficient numbers in five or more categories will not be allowed to enter the certification process until they are able to furnish sufficient case numbers to meet the requirements.

The policy will take effect with residents entering programs July 1, 2001, to June 30, 2002. This information will be communicated to program directors, residents, and the residency review committee.

Recertification activities

The last recertification examination was given June 2, 2001, in San Diego, CA. A total of 24 diplomates participated; 23 passed and one failed. The

results and statistical summaries for the last four years are in Table 1, page 27.

Key feature questions were incorporated into the 2001 recertification examination. The existing exam included 100 multiple choice questions, and 20 key feature items. All diplomates did well on the key feature portion of the exam. More than likely, the number of key feature questions will increase in the future.

Examination results

The most recent written examination (part I) was given March 24, 2001; 67 candidates were examined. The most recent oral examination (part II) was given September 29, 2001; 68 candidates were examined. The fail/pass rates are reported in Table 2, page 27.

ABCRS diplomates

As of September 1, 2001, the board has a total of 1,274 diplomates; 1,095 in active practice and 179 retired or otherwise inactive. Table 3, this page, provides the male/female and international distribution of diplomates.

American Board of Obstetrics and Gynecology

by Robert C. Cefalo, MD, Chapel Hill, NC

ABOG breaks AMA ties

The American Board of Obstetrics and Gynecology (ABOG) has received many queries from diplomates concerning the board's relationship with the American Medical Association (AMA). Regrettably, after a prolonged and frustrating interaction with the AMA regarding an effort to change the name of the board to the American Board of Obstetrics and Gynecology: Women's Health, the ABOG terminated its 70-year association with the organization. Details regarding this action were stated in a September 29, 2000, letter that Gerson Weiss, MD, president of the ABOG, sent to Randolph D. Smoak, Jr., MD, FACS, president of the AMA. The ABOG's officers and directors had hoped that there might have been another choice, but they reluctantly concluded unanimously that the board was left with no realistic alternative.

Exams

The written examination was administered on June 26, 2000, at multiple sites. A total of 1,734 candidates applied for the exam. Of them, 1,290 were new applicants, 1,198 were U.S. medical school graduates (USMGs), 92 were international medical school graduates (IMGs), and 444 were reapplying. Of those reapplying, 288 were U.S. graduates, and 156 were international.

Of the individuals who took the written exam, 1,195 (74%) passed, and 415 (26%) failed. Of the USMGs, 1,116 (79%) passed the exam, while 302 (21%) failed. Among IMGs, 79 (41%) passed, and 113 (59%) failed. First-time takers included 1,106 individuals (88%) who passed the test, and 146 (12%) who failed. U.S. graduates accounted for 1,037 (89%) of the individuals who took the exam for the first time and passed; however, 134 (11%) of the first-time USMGs failed. Among those who had reapplied for the exam, 89 (25%) passed, and 269 (75%) failed.

The principal oral examination was administered in November and December 2000 and in January 2001 in Dallas, TX. A total of 1,543 candidates applied for the oral exam: 12 were disap-

proved ad hoc; 22 were disapproved based on case lists; 72 turned in incomplete-no fee applications; two were no-shows; 33 withdrew from the exam; and 1,402 took the exam. Of the individuals who took the exam, 1,214 (87%) passed, and 188 (13%) failed. Of the candidates who passed the exam, 1,140 (87%) were USMGs, 74 (76%) were IMGs, and 1,002 (89%) were USMGs who took the test for the first time. Of the individuals who failed the exam, 165 (13%) were USMGs, 23 (24%) were IMGs, and 123 (11%) were USMGs who took the test for the first time.

The pass rates for the principal written examination in ob-gyn have remained in a narrow range for over a decade. For U.S. graduates of American medical schools taking the examination for the first time, the pass rate has ranged between 87 percent and 95 percent. For the entire examination, the pass rate has ranged between 66 percent and 76 percent.

As Table 1 (p. 30) shows, the number of applicants for the written examination peaked in the mid-1990s. Since 1997, however, the number of applicants has decreased through the year 2000. This decrease is obviously occurring among reapplicants. The number of first-time applicants has remained relatively constant, reflecting the number of American and Canadian graduating residents who apply for the first time.

The pass rates for all candidates for the oral examination in obstetrics and gynecology have varied from 83 percent to 87 percent for the past decade. The number of applicants for the oral examination remained constant between 1996 and 1999 (range 1,650-1,686). This number dropped abruptly to 1,543 in the year 2000. This trend likely reflects the decreasing total number of applicants for the examination first noted in the years 1997 and 1998 (see above).

Subspecialty examinations

The written examination in gynecologic oncology (GO) was administered June 26, 2000, at multiple sites. The total number of candidates was 94, of which 71 were new applicants, 23 were reap-

plying, and 92 were scheduled. Of those applicants who sat for the written exam, 73 (79%) passed, and 19 (21%) failed. Among first-time takers, 61 (87%) passed, and nine (13%) failed. Among reapplicants, 12 (55%) passed, and 10 (45%) failed.

Subspecialty oral examinations were administered April 10-12, 2000, in Dallas. In the subspecialty of reproductive endocrinology/infertility (REI), 68 individuals took the oral exam, and 47 (69%) of them passed. A total of 805 physicians are board-certified in REI to date. In the subspecialty of maternal-fetal medicine (MFM), 98 individuals took the oral exam, and 87 (89%) of them passed. A total 1,354 are board-certified in MFM to date. A total of 40 individuals took the oral exam in GO; 32 (80%) passed. Currently 662 physicians are board-certified in gynecologic oncology (GO).

The number of applicants, those approved to take the examinations, and the actual number who took the subspecialty written examination in GO, essentially have not changed for the past seven years. The pass rates for the written examination in GO have remained stable at 78 percent to 80 percent since the mid-1990s. The number of applicants for the subspecialty oral examinations, those approved to take the examinations, and the actual number of candidates who took the subspecialty oral examinations are listed by year from 1990-2000 in Table 2, this page.

The major reason candidates did not sit for the subspecialty examination in the past appeared to be the lack of a published thesis. The removal of the requirement for publication appears not to have significantly influenced the decision to take the subspecialty exam. The pass-fail rates for the oral subspecialty examinations are listed in Table 3, this page, by year from 1990 to 1999.

The total number of candidates taking the 1992 subspecialty examinations was 190; and for 1994, the number was 201. For 1995 and 1996, the numbers were 202 and 198, respectively. The number in 1997 was 209, and in 1998, the number was 218. The number in 1999 was 211, and in 2000 the number was 206.

A total of 2,821 diplomates have been issued subspecialty certificates (GO, MFM, REI), of whom approximately 2,600 are currently in practice. This represents approximately 7.9 percent of the total of 33,026 actively practicing ABOG diplomates.

Table 1
Applicants for written examination—
By year

Year	First-time takers	Reapplicants	Total
1995	1,272	859	2,131
1996	1,292	682	1,974
1997	1,284	808	2,092
1998	1,268	555	1,823
1999	1,246	614	1,860
2000	1,290	444	1,734

Table 2
Subspecialty oral examinations

Year	Applied	Approved	Took	% Approved-took exam
1990	232	222	169	76.1%
1991	245	244	191	78.3
1992	252	244	190	77.9
1993	No examinations given			
1994	281	278	201	72.3
1995	266	251	202	80.5
1996	286	246	198	80.5
1997	309	210	209	99.5
1998	289	254	218	85.8
1999	281	234	211	90.1
2000	257	214	206	96.3

Maintenance of certification

Certificate renewal/voluntary recertification written examinations were administered February 28, 2000, at multiple sites. Of those physicians seeking to renew their certificates in ob-gyn, 155 (96%) passed, and six (4%) failed. Of those physicians voluntarily renewing their certificates in ob-gyn, 10 (90%) passed, and one (10%) failed. Of those individuals certified in ob-gyn and GO who were up for certificate renewal, six (100%) passed. The one GO who voluntarily renewed a certificate passed. A total of 15 people certified in MFM sought to renew their certificates and three vol-

untarily sought recertification. Of those individuals certified in REI, seven sought certificate renewal, and they all passed.

The ob-gyn maintenance of certification examination was administered August 28, 2000, in Dallas. Of those physicians applying for certificate renewal, 75 (97%) passed, and two (3%) failed. No one applied for voluntary recertification. Pass rates for the combined February and August examinations in obstetrics and gynecology were 183 (97%) for certificate renewal and 14 (93%) for voluntary recertification.

A total of 4,092 individuals applied for annual board certificate (ABC) renewal and voluntary recertification for 2000. Of the ob-gyn applications, 4,072 were approved, 12 were disapproved, eight were withdrawn, and 316 were incomplete. There were 104 GO applications, of which 100 were approved, none were disapproved, four were withdrawn, and 15 were incomplete. Among the 339 MFM applications, 335 were approved, one was disapproved, three were withdrawn, and 33 were incomplete. With regard to REI, 144 applications were reviewed, 143 were approved, none were disapproved, one was withdrawn, and 20 were incomplete.

For the obstetrics and gynecology portion of the ABC process several trends are obvious. First, approval of applications in 2000 increased from 97.5 percent in 1998 to 99.7 percent in 2000. This slight increase likely represented improved communication between diplomates and the board office. Second, the number of applications was 3,292 in 1999, a 20 percent decrease from 4,098 in 1998, largely because many of the people who did not complete the process in 1998 did not apply again the following year. The increase to 4,092 in 2000 almost certainly represents the influx of another group of diplomates with time-limited certificates choosing this method of certification maintenance. Third, the percentage of diplomates who did not complete the process decreased from 30 percent in 1998 to 11 percent in 1999. In 2000, this number had decreased to 8 percent. As mentioned above, this improvement likely represents the loss of those who failed to complete the process in 1998. Also, this likely includes a new group of diplomates with time-limited certificates and a better understanding of the process. Fourth, more than 70 percent of diplomates using the ABC process in 1998

Table 3
Pass-fail rates
for oral subspecialty examinations

Year	GO		MFM		REI	
	Pass	Fail	Pass	Fail	Pass	Fail
1990	71	29	78	22	65	35
1991	61	39	79	21	63	37
1992	78	22	83	17	55	45
1994	85	15	80	20	69	31
1995	77	23	81	19	75	25
1996	85	15	79	21	73	27
1997	79	21	82	18	64	36
1998	86	14	81	19	64	36
1999	89	11	78	22	76	24
2000	80	20	89	11	69	31

and 1999 did so voluntarily. This percentage fell in 2000 to 57 percent as expected due to the entry of more diplomates with time-limited certificates.

A complete analysis is impossible for the subspecialties after only two years, but certain similarities to the ABC process in obstetrics and gynecology are apparent. Approval of applications has been 100 percent and 98.5 percent in 1999 and 2000, respectively. Although the numbers and years of experience are limited for the subspecialties, those failing and/or completing the process appear to be decreasing. The reasons for this decrease are likely similar to those associated with the maintenance of certification examination in obstetrics and gynecology. Specifically, the attrition in 1999 likely resulted from those diplomates who did not understand the process or who discovered they did not wish to continue this form of recertification. The numbers of subspecialists actually entering the examination process in 1999 (686) and 2000 (510) certainly support these tentative conclusions. The subspecialists, like the diplomates using the ABC process in obstetrics and gynecology, are predominately doing so voluntarily. The 1999 voluntary rate was 77 percent and for the year 2000, it had decreased moderately to 61 percent.

Officers and directors

The ABOG officers for the year ending June 30, 2001, were: Gerson Weiss, MD, president; Michael T. Mennuti, MD, vice-president; Ronald S. Gibbs, MD, treasurer; Robert C. Cefalo, MD, PhD, chairman of the board; Norman F. Gant, MD, executive director; and William Droegemueller, MD, director of evaluation. Directors included: Haywood L. Brown, MD; Larry J. Copeland, MD, FACS; Alan H. DeCherney, MD, FACS; Philip J. DiSaia, MD, FACS; Sherman Elias, MD, FACS; Wesley C.

Fowler, Jr., MD, FACS; Larry C. Gilstrap III, MD; Frank W. Ling, MD; Kenneth L. Noller, MD; Valerie M. Parisi, MD, MPH; Nanette F. Santoro, MD; and Morton A. Stenchever, MD.

Additionally, the following individuals served as the directors and representatives of the subspecialty divisions: Dr. Copeland, division of GO; Dr. Parisi, division of MFM; Dr. Santoro, division of REI. Dr. Stenchever is the director and representative for female pelvic medicine and reconstructive surgery.

American Board of Plastic Surgery

by Bruce M. Achauer, MD, FACS, Orange, CA

Examinations

Oral examination. In September 2000, 279 candidates took the oral examination. Two hundred twenty-seven candidates passed and 52 failed, with a failure rate of 18.6 percent. This failure rate was 2 percent higher than the previous year but compatible with the range of 17-25 percent for the last four years. To date, the American Board of Plastic Surgery (ABPS) has certified 6,125 plastic surgeons. A total of 243 candidates will sit for the oral examination on September 6-8, 2001.

Written or qualifying examination. The written or qualifying examination will be held on September 5, 2001, for approximately 253 candidates. Results of the 2001 written examination will be distributed in November 2001. In 2000, 186 of a total of 243 candidates passed the written examination, with a failure rate of 23.1 percent, which was consistent with prior years.

Subspecialty certification in surgery of the hand (formerly, certificate of added qualifications in surgery of the hand). ABPS administered the 2000 subspecialty certification in surgery of the hand examination to 64 ABPS diplomates, 25 of whom were recertifying. Thirty-eight of 39 diplomates passed the hand surgery examination. The failure rate was 2.6 percent. A total of 25 diplomates sat for the 2000 hand surgery recertification examination, 22 passed, and the failure rate was 12 percent. The 2000 certification examination in surgery of the hand will be administered on August

27, 2000, to 38 candidates, 16 of whom are recertifying. Results will be announced in mid-October.

Core surgery examination. The board decided to abandon the development of a core surgery examination. The board will continue to review the evaluation of the various pathways for prerequisite training and plans a retreat to discuss the test's future in November 2001.

Recertification

The first recertification examination will be offered in 2003. The first time-dated certificates will expire in 2005. The cognitive examination will be offered in a computer test format in four modules: Comprehensive plastic surgery, cosmetic/breast surgery, craniomaxillofacial surgery, and hand surgery. A subspecialty certificate in surgery of the hand will be accepted in lieu of the hand surgery module cognitive examination component of the maintenance of certification process. A number of changes, reflecting the recommendations of the American Board of Medical Specialties Task Force on Competency, have been made in the structure of maintenance of certification process.

American Board of Medical Specialties (ABMS)

Surgical dermatology. ABPS joined the other surgical specialty boards to object to the proposed training in surgical dermatology at the Accreditation Council for Graduate Medical Education.

Competency

The board continues to work with the ABMS regarding the competency issues for the Maintenance of Certification® program.

Subspecialty issues

The American Board of Plastic Surgery, Inc., continues to be committed to the engagement, development, and recognition of subspecialty interests for the purpose of advancing the core of the entire specialty. The board's four advisory councils have been working since May 2000, contributing to the work of the recertification process. The advisory councils reflect the four identified subspecialty modules for the Maintenance of Certification process: comprehensive plastic surgery, cosmetic plastic surgery, craniomaxillofacial surgery, and hand surgery. The members include board directors and nominees from plastic surgery subspecialty organizations.

Public member

The first public member was elected to the board in May 2001. California State Senator Liz Figueroa will serve as a director from 2001 to 2003.

In memoriam

The ABPS mourns the loss of John Bostwick III, MD, FACS, who died January 12, 2001. Dr. Bostwick, of Emory University in Atlanta, GA, was chair-elect and the board's representative to the American Board of Surgery.

In appreciation

The American Board of Plastic Surgery, Inc., honored William B. Riley, Jr., MD, FACS, director, 1994-2001, and chair, 2000-2001, at the May Board Meeting and expressed appreciation for his work.

New officers/directors

The new directors elected to the ABPS are Senator Liz Figueroa; Foad Nahai, MD, FACS; Linda G. Phillips, MD, FACS; and Rod J. Rohrich, MD, FACS.

ABPS Officers for 2001-2002 are Bruce M. Achauer, MD, FACS; John J. Coleman III, MD, FACS, chair-elect; Bruce L. Cunningham, MD, FACS, vice-chair; and David L. Larson, MD, FACS, secretary-treasurer.

American Board of Surgery

by Patricia J. Numann, MD, FACS, Syracuse, NY

During the 2000-2001 academic year, the American Board of Surgery (ABS) continued its efforts to comply with the maintenance of certification program (the "Competence Initiative") developed by the American Board of Medical Specialties (ABMS), and made a number of other decisions that may be of interest to the Fellows of the College.

Competence initiative

As reported last year, in January 2000, the directors endorsed the concept of maintenance of certification as defined by the ABMS, and made preparations to proceed with the development of assessment instruments for each of its component parts:

continuous evidence of high standing within the profession, continued commitment to lifelong practice-based learning and practice improvement, continued evidence of a satisfactory cognitive knowledge base, and continued adherence to high standards of patient care throughout one's professional life. Since then, the board has made progress in a number of different areas. Continuing medical education (CME) requirements have been more stringently defined and applied to the recertification application process; the development of prototypical tools for outcomes measurement has been undertaken by the Vascular Surgery Board of the ABS (VSB (ABS)), by the Surgical Oncology Advisory Council (SOAC), and by the newly created

Pediatric Surgery Board of the ABS (PSB (ABS)); the board and the American College of Surgeons (ACS) have reached a broad agreement whereby the board will provide to the ACS a curriculum, including relative weightings of content categories as well as the keyword content of recent recertification examinations in an effort to more closely align the content of SESAP with the recertification examination—steps designed to clarify better the cognitive material that the board expects all diplomates to master, irrespective of practice patterns; and finally, the board has developed a program for surveillance and action relative to adverse licensure actions relating to competence, the implementation of which has resulted in the revocation of a number of certificates during the past year. Much work remains to be done, particularly with respect to practice outcomes information, which will likely prove especially difficult to obtain and verify in general surgery, the practice of which is so extraordinarily heterogeneous. Nevertheless, the board is committed to the competence initiative, regardless of the obstacles, and anticipates a successful future conclusion to its efforts. Further information on this topic may be found in an article entitled “The measurement of competence: Current plans and future initiatives of the American Board of Surgery” by the ABS executive director, which appeared in the *Bulletin* (86, 4(10):10-15, 2001).

January retreat

Because of concerns about the current structure of graduate surgical education and about the changing demographics of applicants for surgical residency, the board intends to hold a retreat prior to the January 2002 board meeting to focus on the subject of Graduate Surgical Education: Present Trends, Future Initiatives. Although the system is not in crisis, the data indicate that surgery and several of the specialties of surgery are becoming less popular with finishing medical students, as evidenced by the fact that the pool size of applicants for surgical training is contracting. On the other hand and on a brighter note, current data do *not* support the view that the quality of that pool is diminishing. Although no reliable information exists to support the proposition that the length of training in general surgery is at the core of the demographics changes noted (many

other explanations are tenable), the board feels that a reexamination of the possibility of streamlining general surgery training is also in order.

The retreat is designed to address these two issues in some depth. Plans include asking all interested parties to participate, including representatives of program directors' associations, the ABMS, the Accreditation Council for Graduate Medical Education (ACGME) through the Residency Review Committee (RRC) for Surgery, and specific specialty groups. A few critical questions will be identified and all credible available information for each presented. The aim of the retreat is to develop a plan of action to address the two or three most pressing problems identified and to do so against a background of a common database, a common understanding of current regulations, a common appreciation of and respect for the views and concerns of each group, and a common appreciation for what might be a feasible current approach to developing pilot initiatives.

New CME requirements for recertification

Beginning in the year 2002, diplomates holding certificates in vascular surgery, pediatric surgery, and surgical critical care must present evidence that they have accumulated 100 hours of CME relevant to the maintenance of qualifications in those disciplines during the two years prior to submitting an application for recertification. At least 60 of these hours must meet the criteria for Category I activities. The ACS Surgical Education and Self-Assessment Program (SESAP) is included in Category I activities and will be credited as 60 hours. When available, the two modules of the Vascular Self-Evaluation Program (VSEP), developed by the Faculty of Medicine at the University of Toronto, will, when taken together, also constitute 60 Category I hours. In a related development, the directors of the ABS at the June board meeting voted unanimously to accept activities listed under Section 1 (Accredited Group Learning Activities) and under Section 3 (Accredited Self-Assessment Program) of the Royal College of Physicians and Surgeons-Canada Maintenance of Certification Program as equivalent to Category I activities in the U.S. These equivalent activities may be listed as such by Canadian diplomates on their ABS recertification applications. Documentation of specific activities will be required.

New content areas

The directors have concluded that two new content areas should be assessed on future ABS examinations. The first relates to the unique requirements of the geriatric surgical patient; the second pertains to the provision of palliative surgical care. The decision of the directors is based on the conviction that both of these areas are appropriate to include within the scope of knowledge and experience of the well-trained general surgeon.

IT/SBSE irregularities

As noted previously, the board now uses a sophisticated statistical program to detect examination irregularities on the In-Training Surgical Basic Science Examination (IT/SBSE). The program compares each examinee's answer to those of the other 7,000 examinees to determine the incidence of answer sheet concordance and the probability that the duplication occurred by chance (the threshold—a probability of less than one in a million). Suspicious results were noted in 40 programs in 2000, prompting the board to outline the serious nature of the problem in general and to provide more specific feedback to those programs where incidents occurred. For legal reasons, the board cannot release examinee names to program directors.

The number of suspicious matches dropped to 27 in 2001, reflecting the diligence with which program directors monitored the conditions under which the examination was given. However, there were still several cases in which the problem had been noted previously and had persisted over several years. Last year, programs that were "repeat offenders" were warned that continuing problems could result in sanctions. At the June 2001 meeting, the directors of the ABS approved a recommendation that the board adopt the following approach to programs in which repeated and consecutive irregularities were noted. On the first occasion, the program director will be apprised of the irregularities and strongly urged to take appropriate steps. On the second consecutive offense, the program director will be warned that the program is at risk of being denied access to the IT/SBSE. In addition, a copy of that warning will be sent to the chairman of the graduate medical education (GME) committee of the institution involved. On a third

consecutive offense, the program director will be informed that the program is barred from participating in the IT/SBSE for a period of one year. Again, the chairman of the GME committee of the institution will be informed of the decision. The practice of using alternate examination forms for the ABS qualifying examination will be continued.

VSB (ABS)

The Vascular Surgery Board/American Board of Surgery (VSB (ABS)) was created as the vascular surgery sub-board when the ABS reorganized itself into a commonwealth form of governance in 1998. Since then, the VSB (ABS) has compiled an admirable record of accomplishment that is detailed extensively in the VSB (ABS) newsletter sent to all those who hold a vascular surgery certificate (copies are available on request from the ABS office). In addition, as already noted, the VSB (ABS) has endorsed the concept of maintenance of certification and has undertaken a pilot program to measure outcomes for three index procedures: carotid endarterectomy, repair of elective infrarenal aortic aneurysms, and infrainguinal bypass. Those diplomates who have provided especially valuable service to the VSB (ABS) either as members or as special consultants include: G. Patrick Clagett, MD, FACS; Jonathan B. Towne, MD, FACS; Anthony D. Whittemore, MD, FACS; Christopher K. Zarins, MD, FACS; Frank W. LoGerfo, MD, FACS; Julie A. Freischlag, MD, FACS; Keith D. Calligaro, MD, FACS; Bruce J. Brener, MD, FACS; Blair A. Keagy, MD, FACS; Joseph L. Mills, MD, FACS; Norman R. Hertzer, MD, FACS; James O. Menzoian, MD, FACS; Kimberley J. Hansen, MD, FACS; and Dennis F. Bandy, MD, FACS. The board is extremely grateful to each of them.

SOAC

During the past year, the SOAC (whose membership included Drs. Eberlein, Lewis, Coit, Pisters, Townsend, Urist, Winchester, and Ritchie) completed a thorough review of all oncologic items on the qualifying examination, certifying examination, IT/SBSE, and recertification examination, in order to determine the currency, appropriate-

**American Board of Surgery
Summary of 2000-2001 examinations**

Examination	No. of examinees	Pass rate (%)	Diplomates to date
Qualifying	1,296	78	
Certifying	1,267	81	46,395
Recertification	1,223	92	12,283
Vascular surgery qualifying	110	81	
Vascular surgery certifying	85	82	2,055
Vascular surgery recertification	90	98	1,048
Surgical critical care certification	81	97	1,860
Surgical critical care recertification	122	91	539
Hand surgery certification	5	80	218
Hand surgery recertification	11	91	52
Pediatric surgery ITE	74	N/A	N/A
IT/SBSE	<u>7,245</u>	N/A	N/A
Total	11,609*		
N/A = not applicable.			
*4,290 examinees, excluding the IT/SBSE and Pediatric Surgery ITE.			

ness, and accuracy of each. The council intends to continue in this activity on a cyclical basis in the future. The SOAC also reaffirmed its belief that the Society of Surgical Oncology should not endorse in any official way the increasing number of breast fellowships, feeling that to do so would not be in the best interests of training or practice in the discipline of surgical oncology or of surgery in general.

The SOAC has examined at length its role in the maintenance of certification initiative and has decided that it should assess the possibility of investigating a proven and valid outcomes instrument, the National Surgical Quality Improvement Program (NSQIP), created by Shukri Khuri, MD, FACS, for the Veterans Affairs system. To that end, Dr. Khuri was invited to present information to the SOAC at the June board meeting. The SOAC decided that, as a next step, it would work with the executive committee of the NSQIP in an effort to determine the feasibility of using the NSQIP methodology to achieve the aims of the ABS Competence Initiative by examining all oncologic diagnoses for individual surgeons.

PSB (ABS)

In June 2000, the directors of the ABS unanimously approved the establishment of the Pediatric Surgery Sub-Board (now the Pediatric Surgery Board of the American Board of Surgery (PSB (ABS))). The first meeting of the group was held in January 2001. Attendees included the pediatric surgery directors of the ABS (Drs. Rodgers, Krummel, and Georgeson) and Keith Oldham, MD, FACS, representing the American Pediatric Surgical Association (APSA); Donna Caniano, MD, FACS, representing the Surgical Section of the American Academy of Pediatrics; and Moritz Ziegler, MD, FACS, representing the Advisory Council for Pediatric Surgery of the ACS. The PSB (ABS) is heavily involved in the maintenance of certification effort of the ABS and has decided to focus on outcomes analysis, working with the Outcomes and Clinical Trials Center of the APSA. Seven conditions will be the subject of the initial focus. The intent is to create a simple online method that will allow a surgeon to compare his/her short-term outcomes with those of surgeons in their region or nation-

ally in a secure and anonymous fashion. The ultimate goal is to promote practice improvement through a self-assessment of practice outcomes.

Independent vascular surgery board

The directors of the ABS heard a request from the presidents of the Society for Vascular Surgery and the American Association for Vascular Surgery that the ABS support the creation of an independent American Board of Vascular Surgery as a “board down the corridor.” By way of a motion duly made and seconded, the directors voted unanimously not to support the creation of an independent American Board of Vascular Surgery because the best interests of the discipline of vascular surgery are already extremely well served through the VSB (ABS) as evidenced by its numerous accomplishments within the “commonwealth” construct of the ABS created more than three years ago.

Search for a new executive director

The search committee for a new executive director to replace Wallace P. Ritchie, Jr., MD, FACS, upon his retirement on June 30, 2002, continues to work diligently at its duties. It anticipates that a decision will be made by January 2002, allowing for a six-month period of transition.

New and retiring members

The board would like to express its great thanks for the faithful services and wise counsel of the following directors who have retired from active directorship: Frank R. Lewis, Jr., MD, FACS, chairman; Robert H. Bower, MD, FACS; David Fromm, MD, FACS; David E. Hutchison, MD, FACS; Peter C. Pairolero, MD, FACS; and William L. Russell, MD, FACS.

The board is also extremely appreciative of the fine efforts of Jonathan B. Towne, MD, FACS, and David P. Winchester, MD, FACS, who served as extremely effective members of the VSB (ABS) and the SOAC respectively. The board also gratefully acknowledges the many services of those senior members who have earned well-deserved retirement from active examiner status during the past year: John L. Cameron, MD, FACS; R. Scott Jones, MD, FACS; and Hiram C. Polk, Jr., MD, FACS. The board also extends a

welcome to the new directors elected in April: David V. Feliciano, MD, FACS, from the Southeastern Surgical Congress; David N. Herndon, MD, FACS, from the Society of University Surgeons; Irving L. Kron, MD, FACS, from the American Board of Thoracic Surgery; Theodore N. Pappas, MD, FACS, from the Society for Surgery of the Alimentary Tract; Michael G. Sarr, MD, FACS, from the American Surgical Association; Jon S. Thompson, MD, FACS, from the Southwestern Surgical Congress; and Luis O. Vasconez, MD, FACS, from the American Board of Plastic Surgery. The board is also most pleased to welcome James M. Seeger, MD, FACS, to the VSB (ABS) and William C. Wood, MD, FACS, to the SOAC.

Necrology

It is with great regret that we must report the deaths of the following directors and senior members: John Bostwick III, MD, FACS (January 11, 2001); Leonard Rosoff, Sr., MD, FACS (January 21, 2001); and Jerome J. DeCosse, MD, FACS (April 25, 2001).

American Board of Thoracic Surgery

Fred A. Crawford, Jr., MD, FACS, Charleston, SC

Recertification policies

Several years ago, the American Board of Thoracic Surgery (ABTS) announced changes in its recertification policies that would become effective in 2001. In response to an initiative by the American Board of Medical Specialties (ABMS), the board decided to rename the recertification process to better reflect its effort to develop standards and methods to evaluate physician specialists following their initial certification. Accordingly, the ABTS, along with the other medical certifying boards, has begun the transition toward a "maintenance of certification," rather than "recertification," process.

A valid ABTS certificate became an absolute requirement for entering the recertification process in 2001 and beyond. As of last year, the only pathway for renewal of an invalid certificate is to take and pass the written and the oral certifying examinations. Effective in 2001, the continuing medical education (CME) requirement is 70 category I credits in either cardiothoracic surgery or general surgery earned during the two years prior to applying for recertification. Not all category I credits will be allowed; for instance, Self-Education/Self-Assessment in Thoracic Surgery (SESATS) and Surgical Education and Self-Assessment Program (SESAP) are the only self-instructional material acceptable for CME credit. The Physicians Recognition Award for recertifying in general surgery will not be accepted in fulfillment of the CME requirement.

Other specific CME requirements will be published in a recertification booklet of information. The booklet contains information about how the operative index case requirements should be recorded and tracked, which now has two components: surgical volume or intensity and index case distribution. All residents must perform an annual average of 125 major operative cases each year with a minimal number of 100 in any one year.

In addition, beginning in 2001, the ABTS no

longer publishes the names of individuals who have not recertified. Listing diplomates with invalid certificates in directories published by the ABMS has proven to be confusing to credentialing bodies of various hospitals, managed care organizations, and patients. In addition, no other board of the ABMS publishes the names of individuals holding invalid certificates.

All diplomates should be aware of the changes in the requirements in anticipation of renewing their own certificates. The board feels that maintenance of certification is important to the public and to each physician's professional career. All diplomates need to be up-to-date with regard to the requirements for recertification, so they are prepared when the time comes to recertify.

Recertification activity

In 2000, 261 diplomates recertified: 125 for the first time, and 136 for the second time; 205 diplomates used the SESATS computer version, and 56 used the paper and pencil version.

Time-limited certificates were first issued in 1976. Diplomates certified after 1975 must be recertified within 10 years of the date of the original certification in order to maintain their certification. Diplomates with time-limited certificates may apply within three years of the expiration of their 10-year certificate. Diplomates certified before 1976 do not require recertification and are considered to hold unlimited certificates.

The board emphasizes the importance of recertification in correspondence with diplomates whose certificates are due to expire and informs them that an expired certificate is no longer valid. The board office is experiencing an increasing number of inquiries with regard to the status of diplomates of the board. The inquiries are coming from various agencies, such as hospital administrations, credentials committees, HMOs, insurance companies, other third-party payors, government agencies, and members of the legal profession.

ABTS recertification activity						
Date of orig. cert.	Total no. cert.	Total no. recert. first time	Percent recert.	Total no. recert. second time	Percent recert. second time	
Prior to 1976	N/A	64	--	4	--	
1976	160	142	89%	128	80%	
1977	146	129	88	108	74	
1978	154	141	92	119	77	
1979	158	147	93	121	77	
1980	110	100	91	89	81	
1981	131	124	95	84	64	
1982	159	147	92	53	33	
1983	136	122	90	--	0	
1984	135	125	93	--	0	
1985	120	119	99	--	0	
1986	147	140	95	--	0	
1987	141	137	97	--	0	
1988	136	129	95	--	0	
1989	159	155	97	--	0	
1990	122	114	93	--	--	
1991	122	94	77	--	--	
1992	142	51	36	--	--	

Examinations

The written examination was administered on November 19, 2000, in Chicago, IL. In all, 150 individuals took the test, and 77 percent of them passed. The November 2000 written examination was the eighth criterion-referenced examination administered by the ABTS. The philosophy of criterion-referenced testing is based on the concept that candidates should be measured against a standard of knowledge predetermined by the board rather than against each other, as is the case in a norm-referenced examination. Furthermore, the examination consultant committee, established in 1989, continues to be a vital component in the development of the written examination. The committee meets in September each year to review questions written by the consultants. At its meeting in 2000, 80 questions were retained for future use in the written examination.

The board conducted its fifth criterion-referenced oral examination on June 9, 2001, in Chi-

cago. With this type of examination, the board applies statistical methods to equate the examination. The purpose of statistically equating is to place alternative forms of the examination on a scale such that all candidates are compared to a single standard. Equating is accomplished through a statistical process that weighs each facet of an examination form. The basic premise of this analysis is that all candidates have a comparable opportunity to pass because they are measured against the same criterion standard. In 2001, a total of 120 (91%) candidates passed the examination and 12 (9%) candidates failed it.

Additionally, 362 individuals participated in the 2001 in-training examination administered on April 7, 2001. This exam consists of 80 general thoracic and 80 cardiac questions distributed among the various areas of the specialty in a manner similar to the certifying examination. A total of 182 candidates took it via the Internet and 180 took it using paper and pencil. Score reports and comparative results were posted on

the Internet for all test takers. The 2002 in-training examination will be available on the Internet only as proposed by the ABTS committee to study computer-based testing. The practice examination is required of all test takers.

Applications

The time frame between the deadline for submission of an application to enter the certification process (August 1) and the subsequent approval process has been condensed to just a few weeks now that the schedule for the examination has been changed to November. Therefore, it is extremely important for all candidates to submit a complete and accurate application as the original submission. There will be no time for corrections or additions. The board urges the program directors to help their residents with the application process by carefully reviewing the application before signing off on it and by informing their residents about the importance of an accurate and complete application.

The board, as of its meeting in October 1999, will no longer allow residents to submit applications on August 1 pending certification by the American Board of Surgery in September. It is not administratively possible to continue to allow this extension since the time frame has been compressed by three months. Thus, the American Board of Thoracic Surgery will no longer accept incomplete applications and the August 1 deadline for submission of the application is firm for all residents.

It should be noted that the board application is now available online and may be used with the CTSNet operative case log program. Information is available on the ABTS Web site, www.abts.org, under the tab marked "certification."

Finances

The annual mandatory certification maintenance fee of \$100 is required of all active diplomates, age 65 and under. Beginning in 2001, the fee is cumulative. This fee helps defray administrative expenses related to maintaining and utilizing the diplomate information on the board's computer system. The board will not respond to inquiries about the diplomate's certification status until the fee is paid each year.

Strategic planning

Several items of interest resulted from the 1999 strategic planning process, including: (1) the board approved a motion to change the name of the recertification committee to "maintenance of certification committee"; (2) the board approved a motion stating the ABTS assumes responsibility for the assessment of competency for thoracic surgeons; and (3) the board approved a motion to make certification by the American Board of Surgery optional at some point in the future.

New board members

In October 2000, the search committee for the next secretary/treasurer presented its list of nominees and William A. Gay, Jr., MD, was elected to the post. At the 2000 fall board meeting there were no retirements or additions to the Board. Fred A. Crawford, Jr., MD, FACS, will continue for another year as chairman of the board, and Gordon N. Olinger, MD, FACS, will serve an additional year as a director before becoming the examination chairman. □

Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first and only Web-based and continually updated surgical reference. A sample chapter and detailed information on *ACS Surgery*, including how to save \$20 on a subscription to the online version, is available by visiting www.acssurgery.com/learnmore.htm.

V. Cost-Effective Nonemergency Surgery
2. Risk Stratification, Preoperative Testing, and Operative Planning. Nicolas V. Christou, MD,

FACS; Douglas W. Wilmore, MD, FACS; Alden H. Harken, MD, FACS; and Jyoti Arya, MD. Intrinsic to the purpose of an operation—to make a patient's subsequent life better than it would be if the procedure is not performed—is careful consideration of the risk of complications and of the immediate (and, in some cases, prolonged) disability associated with the operation. In their new chapter, Drs. Christou, Harken, Wilmore, and Arya review the key elements of assessing and ameliorating operative risk.

Despite the wide range of technology available to evaluate a patient preoperatively, history and the physical examination remain the most effective means of identifying risk factors associated with coexisting disease. Combined with the physical examination, history is diagnostic in 75 percent to 90 percent of patients. Healthy patients younger than 40 years of age need not undergo any preoperative laboratory evaluation unless a specific test is indicated by a relevant detail in the history or the physical examination (for example, a finger-stick hematocrit in a young woman with dysmenorrhea). There are, however, certain tests that may be useful in older patients: Some authors recommend obtaining electrocardiograms (ECGs), chest X rays, serum creatinine levels, glucose levels, and hemoglobin concentrations for patients older than age 40.

By far the greatest portion of postoperative risk comes from cardiovascular factors. If the patient reports no exertional angina, fatigue, shortness of breath, or syncope, and if a resting ECG reveals no evidence of coronary artery disease, the surgeon may proceed with elective surgery without further testing. If the patient does not or cannot communicate well or coronary artery disease is a possibility, an exercise ECG should be obtained. There are several risk-reduction approaches for patients at increased risk due to cardiovascular factors—for example, the maintenance of intraoperative normothermia, scrupulous control of heart rate and

Continue to keep current

Online access to *ACS Surgery: Principles and Practice* is now only available to paying subscribers. As a special member benefit for ACS Fellows, Associates, and Candidates who are not already subscribers to *ACS Surgery*, we are pleased to offer a \$50 discount on subscriptions to the online version of the reference. You pay an annual subscription fee of \$149, instead of the customary \$199 rate. Please go to www.acssurgery.com/learnmore.htm for more information and to save \$50 on the online version.

Subscribers to the print and CD-ROM versions of *ACS Surgery* continue to receive free online access to the monthly updates and full text by visiting www.acssurgery.com. You will need your nine-digit account number, which can be obtained by calling 800/545-0554 or 914/962-4559 (outside the U.S.), by faxing 914/962-5076, or by e-mailing acssurgery@dwweb.net. Updates are also available quarterly through subscription to the *ACS Surgery* CD, which incorporates every online update from the previous three months, and yearly through subscription to the annual hardcover edition of *ACS Surgery*, which incorporates every online update from the preceding year.

blood pressure in the perioperative period, and administration of beta blockers perioperatively.

Subscribers may view the full text of "Risk Stratification, Preoperative Testing, and Operative Planning" at www.acssurgery.com.

II. Care in the ICU

6. Renal Failure. Anthony A. Meyer, MD, PhD, FACS; Bruce A. Cairns, MD; and Renae Stafford, MD. Drs. Meyer, Cairns, and Stafford have thoroughly updated their informative review of the approach to the patient with renal failure. Although most patients with acute renal dysfunction do not progress to acute renal failure (ARF), the condition remains a complex problem associated with a high mortality in surgical patients. The annual incidence of ARF is approximately 50 to 100 cases per million of population. And most of the renal failure encountered in contemporary surgical care is not single-organ failure; rather, it occurs in the context of the simultaneous dysfunction or failure of several organ systems. Mortality of ARF is greater than 50 percent. Hence, prevention and early recognition of acute renal dysfunction are of paramount importance. In addition, documentation of the dysfunction is important because it may help prevent recurrent problems in the future. Chronic renal failure (CRF), which is irreversible, may be caused by a number of factors. Diabetes mellitus, hypertension, glomerular diseases, obstructive disease with chronic pyelonephritis, congenital hypoplasia or aplasia, tubulointerstitial diseases, and polycystic disease are the most common causes of CRF. These patients will have varying degrees of renal insufficiency and (as in patients with acute renal failure), a good history and physical examination is critical in their evaluation in the perioperative period.

Subscribers may view the full text of "Renal Failure" at www.acssurgery.com.

VIII. Common Clinical Problems

5. Jaundice. Jeffrey Barkun, MD, FACS, and Alan Barkun, MD. In their newly updated chapter, Drs. Barkun and Barkun revisit their problem-based approach to the jaundiced patient, which is centered on continuous assessment of the information provided by successive clinical and laboratory investigations, as well as the information obtained through modern imaging. They also propose a clas-

sification of jaundice that addresses the therapeutic options most pertinent to surgeons. Modern decision making in the approach to the jaundiced patient includes not only careful evaluation of anatomic issues, but close attention to patient morbidity and quality-of-life concerns as well as a focus on working up the patient in a cost-effective fashion. For optimal treatment, an integrated approach that involves the surgeon, the gastroenterologist, and the radiologist is essential.

Looking ahead

New and updated chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in the first part of 2002 include the following:

- "Pancreatic Procedures," by John L. Cameron, MD, FACS, and Keith D. Lillemoe, MD, FACS.
- "Outpatient Surgery," by Richard B. Reiling, MD, FACS, and Daniel P. McKellar, MD, FACS.
- "Open Esophageal Procedures," by Richard Finley, MD, FACS, and John Yee, MD.
- "Emergency Department Evaluation of the Patient with Multiple Injuries," by Felix Battistella, MD, FACS.
- "Molecular and Cellular Mediators of the Inflammatory Response," by Vivienne M. Gough, MB, ChB, Constantinos Kyriakides, MD, and Herbert B. Hechtman, MD, FACS.
- "Thoracoscopy," by Valerie W. Rusch, MD, FACS, and Raja Flores, MD.
- "Esophageal Procedures: Minimally Invasive Approaches," by Marco G. Patti, MD, FACS, and Piero M. Fisichella, MD, FACS. 

Mr. Kelly is editor, *What's New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

Socioeconomic tips of the month

Answers to common hotline questions

Q. When our surgeon performs sentinel node biopsies, he also injects blue dye to identify the sentinel nodes. How should we report this aspect of treatment?

A. When a surgeon performs sentinel node biopsies with injection of blue dye, it is reported by using the CPT codes for the biopsy or excision of the sentinel node (38500-38530) plus CPT code 38792 (Injection procedure; for identification of sentinel node) to indicate dye should be used.

Q. Is there a CPT code to report the collection of a blood specimen through a port or a catheter rather than a routine venipuncture?

A. The procedure should be reported with CPT code 36540 (collection of blood specimen from a partially or completely implantable venous access device).

Q. Is code 31622 considered a unilateral code?

A. CPT code 31622 (Bronchoscopy; rigid or flexible; diagnostic, with or without cell washing; separate procedure) is considered a bilateral code. Therefore, the Correct Coding Initiative edits preclude the use of the bilateral modifier (modifier -50) with 31622.

Q. How do I report the removal of spider veins by laser?

A. There is no specific CPT code for the laser removal of spider veins. You should use CPT code 37799 (Unlisted procedure, vascular surgery) to report the procedure. Be sure to send a copy of the operative report with the claim.

All specific references to CPT terminology and phraseology are: CPT only © 2001 CPT American Medical Association. All rights reserved.

Around the corner

April

- Quarterly update to 2002 *Correct Coding Edits* (NCCI 8.1) effective April 1.
- ACS-sponsored advanced coding workshop for surgeons on April 26 in Atlanta, GA. (Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdwkshop.html> or contact Jeff Smith at 312/202-5244 to register.)

May

- ACS-sponsored basic and advanced coding workshops for surgeons, cosponsored by the Rhode Island Chapter, on May 23-24, 2002, in Baltimore, MD. (Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdwkshop.html> or contact Jeff Smith at 312/202-5244 to register.)

Q. Can we use code 44005 (Enterolysis, freeing of intestinal adhesion, separate procedure) for the lysis of adhesion when our doctor is doing a hernia repair, especially if the adhesions were very extensive?

A. CPT code 44005 is defined as a separate procedure and is considered an integral part of many procedures, including hernia repair. If the surgeon performs both the hernia repair and extensive lysis of adhesions, use the -22 modifier on the hernia repair code.

Keep in mind that the use of the -22 modifier requires an operative dictation showing the added work and diagnoses, as well as a special report explaining the additional diagnoses and how the work involved in the procedure had added difficulty. Code 44005 should only be reported if the entire procedure took an additional 50 percent longer to complete than a typical hernia repair.

continued on page 46

HCV conference to be held in June

The National Institute of Diabetes and Digestive and Kidney Diseases and the National Institutes of Health (NIH) Office of Medical Applications of Research will present an NIH Consensus Development Conference titled Management of Hepatitis C: 2002, June 10-12, 2002, at the Natcher Conference Center, National Institutes of Health, Bethesda, MD.

The hepatitis C virus (HCV) is the leading cause of liver disease in the U.S. and the most common cause of cirrhosis and hepatocellular carcinoma. It is also the most common reason for liver transplantation. Almost 4 million people in this country are believed to be infected with HCV.

The conference will review the most recent developments regarding HCV management, treatment options, and the widening spectrum of potential candidates for treatment. The meeting will explore the following key questions: (1) what is the natural history of hepatitis C? (2) what is the most appropriate approach to diagnose and monitor patients? (3) what is the most effective therapy for HCV? (4) which patients with HCV should be treated? (5) what recommendations can be made to patients to prevent transmission of HCV? and (6) what are the most important areas for future research?

During the first day-and-a-half of the conference, experts will present the latest HCV re-

search findings to an independent nonfederal panel. The panel will weigh all the scientific evidence, then present its draft statement to conference attendees on the final day of the conference. James L. Boyer, MD, Yale University School of Medicine, New Haven, CT, will chair the panel.

To register for this conference or to obtain further information, visit the NIH Consensus Development Program Web site, <http://consensus.nih.gov>, or contact Channet Williams, AIR/Prospect Center, 10720 Columbia Pike, Silver Spring, MD 20901; tel. 301/592-2130, fax 301/593-5791, e-mail hepatitisc@prospectassoc.com.

Collection services now available through the College

The American College of Surgeons has contracted with National Credit Systems (NCS), one of the nation's leading collection service/accounts receivable management firms, to provide ACS members with collection services for dealing with delinquent accounts.

Reasonable rates, tenacious service, and a high percentage of recovery are benefits the

College can provide because of this relationship.

According to the terms of the agreement with NCS, members of the College will pay only a flat fee for these services as opposed to arrangements offered by other companies, which charge a percentage of the bill or a flat fee and a percentage. NCS will pursue small and large balances for indi-

vidual or business accounts and will give equal attention to both.

Because of their customer service orientation, NCS reports a recovery rate that is more than twice the national average. For further details and to sign up for the program, visit <http://nationalcredit.com/acs.html>.

No Second Opinion Needed.



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SOCIOECONOMIC TIPS OF THE MONTH, from page 43

Q. How would you code for the removal of an old pacemaker?

A. Use CPT code 33233 (Removal of permanent pacemaker pulse generator).

Q. How do I report the closure of an enterovesical (colon to bladder) fistula?

A. The most appropriate code would be 44660 (Closure of enterovesical fistula; without intestinal or bladder resection). Code 44661 would be used if some bladder or intestine was resected in addition to the closure.

Q. What code should I use for removal of a lipoma when I can't find a specific code for the anatomical site?

A. You should use the CPT code for excision of a benign tumor listed under the specific body site. For example, you would use code 21555 (Excision tumor, soft tissue of neck or thorax; subcutaneous) for the excision of a lipoma for neck or thorax.

Q. How do I code for the removal of an infected arteriovenous graft?

A. You should report CPT code 35903 (Excision of infected graft; extremity). 



ACS launches CME Joint Sponsorship Program

The Office of Continuing Medical Education of the American College of Surgeons has announced the launch of a CME Joint Sponsorship Program. The program will be conducted by the ACS as a national accrediting organization under the Accreditation Council for Continuing Medical Education and will offer cost-effective joint sponsorship to not-for-profit surgical organizations nationwide for the CME programs and meetings.

Further information and application materials are available from the program's administrator, Kathleen Goldsmith, at JSP@facs.org.

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Highlights of the Board of Regents meeting

February 8-9, 2002

by Paul E. Collicott, MD, FACS,
Director,
Division of Member Services

Executive Services

501(c)(6) corporation

The ACS Board of Regents approved a business plan to establish a 501(c)(6) corporation. A task force was created and charged with developing and submitting a formal business plan to establish a 501(c)(6) corporation affiliated with the College. Task force recommendations included:

- The College should establish a separate 501(c)(6) corporation with a name similar to its own.
- The first goal of this new entity would be to facilitate an expanded legislative support program, including the creation of a political action committee. Other potential activities outside the scope of the Division of Advocacy and Health Policy could be assigned to this entity in the future following deliberation by the Board of Regents.
- A Board of Directors comprising the same individuals who serve on the Board of Regents would govern activities conducted by the new corporation. The College's Executive Director would serve as its Chief Executive Officer. A separate governing body would be appointed by the Board of Directors to oversee policies and operations pertaining to the political program.
- The name of this corporation will be the American College of Surgeons Professional Association.

Ad hoc committee to study the structure of the Board of Regents

The Executive Committee of the Board of Regents approved a new ad hoc committee to review the structure, composition, and terms of the Board of Regents. The ad hoc committee has been charged with addressing five specific issues: (1) length and number of terms; (2) re-

tirement/resignation; (3) public members; (4) international members; and (5) adequate balance (specialty, geography, diversity, academic/community practice, and so forth).

Proposed committee assignments

The Board of Regents approved changes in committee assignments under reorganization, along with the dissolution, com-

bination, and addition of new committees. The Regents also approved the revised *Rules and Guidelines Governing College Committees*.

ACS Bylaws

The Board of Regents approved several changes in the current *Bylaws* of the American College of Surgeons. The changes concerned the renamed Member Services Liaison Committee, formerly the Fellowship Liaison Committee. The Member Services Liaison Committee will also review matters formerly discussed within the Organization Liaison Committee, which was dissolved.

Council of Medical Specialty Societies (CMSS)

During the CMSS meeting in November 2001, the President reported and the Council reaffirmed the CMSS's current priorities—some of which include:

- Actively collaborating with the American Board of Medical Specialties (ABMS) in its plan to implement maintenance of certification.
- Leading the repositioning of continuing medical education, while working to improve and support the Accreditation Council for Continuing Medical Education (ACCME) accreditation process.
- Continuing active coordinated representation from the CMSS to the Accreditation Council on Graduate Medical Education (ACGME), ACCME, and ABMS and providing liaison with

other organizations including the American Association of Medical Colleges, Educational Commission for Foreign Medical Graduates, and National Board of Medical Examiners.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

At the November 9-10, 2001, meeting, the JCAHO Board of Commissioners approved the operating plan for the year 2002. The plan includes, among other activities:

- The launching of a Critical Access Hospital Program.
- A 25 percent reduction in survey fees and the creation of a new survey process for small hospitals.
- Modifications to the ORYX outcomes initiative in long-term care and home-care programs to ease the burden and cost of compliance.
- Continuation of the Accreditation Improvement Initiative.
- Continuation of improved surveyor training and survey management.
- Launch of a new Disease-Specific Care Accreditation Program.
- Sponsoring and participating in national and international conferences relating to health care safety and quality improvement.

Development Program

Gifts and pledges received during the 2001 calendar year continue to be recorded and will exceed \$1 million for the fourth consecutive year. Among the gifts received were: an unrestricted educational grant from Merck & Co., Inc.; a significant cash contribution from an individual Fellow; and notice of a forthcoming bequest from the estate of the late Claude E. Welch, MD, FACS.

The Subcommittee on Major and Planned Gifts will be working during the coming year to provide detailed information regarding estate planning and opportunities to make bequests to the College through wills and trust arrangements.

The Subcommittee on Corporations and

Foundations will again sponsor a breakfast meeting with representatives of medical industry during the 2002 Clinical Congress. A significant increase in corporate gifts was reported for the past calendar year.

Society of American Gastrointestinal Endoscopic Surgeons (SAGES)

SAGES is developing a program designed to set a minimum standard of knowledge and skills in laparoscopic and minimally invasive surgery, which is meant to be applied nationally as an educational and credentialing tool for related procedures. SAGES recognizes the need to work with the College and other major national organizations to administer this program and intends to formally request a partnership with the College.

Honors Committee

R. Scott Jones, MD, FACS, ACS President, is Chair of the Honors Committee. The committee reviews the status of awards and honors, and considers nominations for Honorary Fellowship, the Distinguished Service Award, the Sheen Award, the Martin Memorial Lecturer, and the Jacobson Innovation Award. The Honors Committee welcomes suggestions of possible candidates from the Fellows, Regents, Officers, College committees, councils, and staff.

Committee on Ethics

The Regents approved a Scope of Practice document, prepared by the Committee on Ethics, for inclusion in the ACS *Statements on Principles*.

Handheld Surgical Case Log System

The Board of Regents approved the College's involvement in a potential pilot project to develop a hand-held surgical case log system for Fellows.

Report of the Executive Director

Thomas R. Russell, MD, FACS, Executive Director, shared his thoughts and updates with the Regents.

In addition to expressing his personal thanks for their support, he touched on: the need for the College to become proactive with the issue of professional liability insurance; the need for the College to meet and exchange information with all medical and surgical disciplines; opening the College to new categories of membership; possible expansion of the 501(c)(6) corporation beyond legislative matters to meet the College's responsibilities to its membership; and the importance of spreading the word about the "joy of surgery" in these tough practice times.

Journal of the American College of Surgeons (JACS)

JACS ranks number 11 of 136 surgery journals. In addition, JACS is very proud of its CME-1 program record. It fills a void for surgery CME and can provide up to 24 credits each year at no cost to Fellows of the ACS; credits cover all disciplines and some are multidisciplinary, in keeping with the American Board of Surgery's mandated new requirements.

As of January 16, 2002, JACS has provided 8,432.75 CME credits to 1,382 Fellows. States with the highest use of the CME program include California, New York, Florida, Pennsylvania, North Carolina, and Ohio. The U.S. is where the CME program is most widely used, followed by Canada, Mexico, and India. The program has had registration from as far away as Mongolia and Afghanistan. In November 2001, JACS' Online CME-1 Program received a certificate award for a technology-based distance education program from the American Society of Association Executives. The award recognizes excellence and innovation.

Communications

Media relations

The American College of Surgeons, the Joint Commission on Accreditation of Healthcare Organizations, the American Academy of Or-

thopaedic Surgeons, and the American Medical Association participated in a December 5, 2001, joint press conference on wrong-site surgery. Dr. Russell represented the College at the press conference and underscored the importance of open communication among all members of surgical teams, and that all team members must share responsibility in the patient's care.

Public information activities

The 2002/2003 edition of the College's annual *Publications & Services Catalog* is nearing completion. This year's catalog will be available only online through the College's Web site.

Communications/informatics activities

To assist medical students in finding a match with a surgical residency position, a new section made its debut on the ACS Web site in early November 2001. Entitled "So You Want to Be a Surgeon," this career information resource and online database was expanded to include information on all of the surgical specialties, and is updated on an ongoing basis. During the month of December, this new section of the College's Web site received 6,291 hits. An advertisement promoting the medical student section of the ACS Web site was placed in the September, October, and November 2001 issues of the medical student magazine *The New Physician*.

Following the Clinical Congress, a new resource area of the ACS Web site was developed to provide Fellows and other visitors with information on bioterrorism and unconventional civilian disasters. The area also features links to other sites that contain helpful information on these issues.

Program information and an online registration form for the 2002 Spring Meeting in San Diego were posted on the College's Web site in February. The preliminary program for the Spring Meeting was published in the January issue of the *Bulletin*.

Work has begun on an online version of the listing of benefits for members of the College.

It is anticipated that the listing will be finalized and posted online sometime during the spring. A print version will be developed and published in the *Bulletin*, and as a separate brochure.

ACS branding program

At its October 2001 meeting, the Board of Regents agreed to defer action on a national branding/marketing-advertising program for the ACS in light of the September 11, 2001, terrorists attacks. Implementation of the program was further postponed after the announcement of Medicare physician payment cuts, coupled with the fact that insurance companies are pulling out of the malpractice business and malpractice premiums are escalating.

Since the deferral, a new approach has been taken to develop materials internally for various surgical audiences the College would like to reach, and to establish a workgroup for this purpose. The Board of Regents approved the recommendation of its Communications Committee that a strategic planning session be held in June 2002.

Division of Advocacy and Health Policy

Medical liability reform

Fellows continue to identify tort reform as one of their top legislative priorities. The College has supported a series of medical liability reforms that mirror those enacted in California under the Medical Injury Compensation and Reform Act. To advance these reforms the College is actively participating in three medical malpractice reform coalitions.

In the House, legislation has been introduced by Rep. Patrick Toomey (R-PA) that encompasses all of the College-supported malpractice reforms. On the other side of Capitol Hill, Sen. Mitch McConnell (R-KY) has introduced legislation that is similar to Rep. Toomey's bill.

The College is participating in a new multispecialty task force convened by the American Medical Association that intends

to develop and coordinate comprehensive state and federal strategies. The Division also plans to provide advocacy resources on medical liability reform to the chapters.

Medicare physician payment

On November 1, 2001, the Centers for Medicare & Medicaid Services (CMS) published a final rule for the 2002 Medicare physician fee schedule. The regulation included a 5.4 percent across-the-board cut in payments for all physician services beginning in 2002. Dr. Russell traveled to Washington, DC, on October 23, 2001, to meet with the CMS Administrator, Tom Scully, to express the surgical community's concern about the impending payment reduction, particularly since it follows other significant pay cuts for surgical services that have occurred over the course of the past decade.

The College is continuing its efforts to pressure Congress to immediately address both the 5.4 percent negative payment update and the problematic sustainable growth rate (SGR) formula. In addition, the College has joined 12 other medical and surgical specialty societies to form the Coalition for Fair Medicare Payment.

On December 27, the College submitted comments to CMS regarding the agency's final rule on the 2002 Medicare physician fee schedule. The College reiterated concerns over the agency's calculation of the payment update for 2002 and took CMS to task over the unexpected reduction of practice expense RVUs for selected codes with no physician work (zero-work pool). The College took special issue with the agency's failure to address this change first in a proposed rule, particularly because it will have a significant impact on vascular surgeons who perform noninvasive diagnostic studies in their offices.

Evaluation and management (E&M) codes

The AMA has formed a workgroup to examine E&M codes after being asked by the CMS to review the current coding structure. The College, in response to a request from the AMA,

named John T. Preskitt, MD, FACS, ACS Regent, to the workgroup, with Frank G. Opelka, MD, FACS, serving as his alternate. The College will represent the perspective of the entire surgical community during the workgroup's deliberations.

Trauma systems funding

The 107th Congress approved \$3.5 million for FY 2002 for the Trauma Care Systems Planning and Development Act. This statute provides federal grants to assist states in planning, developing, and coordinating statewide trauma care systems.

Congress had also approved \$3 million in FY 2001 funding for the trauma program, most of which has been used by the Health Resources Services Administration to conduct a state-by-state needs assessment of trauma system capabilities around the country. It is anticipated that the results of the study will clearly illustrate the patchwork nature of the nation's trauma care network and bolster arguments for a significant increase in program funding.

The division staff are working with the College's Committee on Trauma (COT) on initial steps for persuading Congress to reauthorize the program for an additional four years. The College is working with Congress to address the nation's preparedness to respond to acts of bioterrorism, specifically trauma care system needs.

On October 9, 2001, the College sent a letter to former Pennsylvania Governor Tom Ridge, Assistant to the President for the Office of Homeland Security. The letter outlined how the College and its COT could be helpful in his efforts to enhance the country's ability to respond to acts of terrorism. The letter also highlighted the College's long history and involvement in improving the standards and quality of care governing the treatment of trauma patients.

On October 23, 2001, the College sent letters to key policymakers in Congress regarding two College statements on disaster preparedness that were approved during the Clinical Congress in New Orleans.

Quality of care

Dr. Russell met with two leaders of private sector organizations that are interested in health care quality measurement and improvement: Suzanne Delblanco, PhD, executive director of the Leapfrog Group, and Margaret O'Kane, president of the National Committee for Quality Assurance. Both groups expressed an interest in working with the College on quality issues pertaining to surgery and surgical patients.

Certified Registered Nurse Anesthetists (CRNAs)

On September 5, 2001, the College submitted comments to CMS supporting its decision to restore the long-standing requirement that CRNAs be supervised by physicians, as well as the proposal for a comprehensive Agency for Healthcare Research and Quality (AHRQ) outcomes study. Regarding states' ability to opt out of federal supervision requirements, the College cautioned CMS that these applications should be carefully reviewed and evaluated before they are granted.

Chapter Visit Program

Chapters continue to be encouraged to annually visit their members of Congress as part of the College's Chapter Visit Program. The following 2002 dates are available for Chapters to visit Washington, DC: February 26-27, March 12-13, March 18-19, April 9-10, April 22-23, May 7-8, May 21-22, June 10-11, June 12-13, and July 15-16.

Assistants at surgery

The next *Physicians As Assistants at Surgery: 2002 Study* will be available in mid-February 2002.

Coding workshops

On July 30, 2001, the division issued a request for proposals to seek competitive bids for the presentation of coding workshops for Fellows and their staffs. A one-year contract with Karen Zupko and Associates to present six

basic and four advanced coding workshops was recommended and approved.

An advanced coding workshop will be presented on April 16, 2002, at the Spring Meeting in San Diego, CA. John T. Preskitt, MD, FACS, will serve as course director.

Coding hotline

On October 18, 2001, the division issued a request for proposals seeking competitive bids for the coding hotline. A one-year contract renewal with Physician Reimbursement System, Inc. (PRS), was recommended and approved with the following adjustments to previous agreements: PRS will expand the hours of the hotline's availability by two hours to provide additional live consultant access to Fellows who practice on the West Coast; PRS will provide the ACS with at least one coding tip per month, suitable for printing in the *Bulletin*; and PRS will work with the College to ensure that the hotline conforms to federal privacy requirements. If PRS successfully meets the benchmarks contained in the new contract, it is renewable for an additional two years. Staff will perform periodic checks with Fellows who have used the hotline to determine their satisfaction with the service.

Medicare payment update

The Health Policy Steering Committee (HPSC) reviewed and agreed to a proposal by 13 specialty societies to establish a task force, using outside lobbying consultants, to pursue a remedy in Congress to the Medicare payment problem.

Liability insurance

The HPSC enthusiastically endorsed the notion of exploring partnerships with insurance companies in which surgeons participating in College-sponsored educational programs receive discounted premiums.

Nursing shortage

The HPSC reviewed a position statement from the Association of periOperative Registered Nurses. The committee did not endorse

the statement. A subcommittee comprised of L.D. Britt, MD, FACS; Stephen Mathes, MD; and Andrew Warshaw, MD, FACS, has been appointed to draft a College statement on the topic.

State advocacy

The HPSC expressed support for the concept of devoting more College resources to providing centralized support to the chapters in an effort to address their administrative and health policy needs.

AMA House of Delegates

Drs. Thomas Russell, Charles Logan, Richard Reiling, Amilu Rothhammer, Thomas Whalen, and Chad Rubin—all ACS Fellows—represented the College at the December 1-5, 2001, meeting of the AMA House of Delegates, in San Francisco, CA. The Surgical Caucus of the AMA held its meeting with an educational focus on bioterrorism. Peter Duhamel, MD, FACS, assumed the position of Chair of the Caucus, and LaMar S. McGinnis, Jr., MD, FACS, was elected as Treasurer.

The College introduced a resolution regarding prompt credentialing that was overwhelmingly supported by the House of Delegates. The resolution directs the AMA to develop model state legislation to reflect this policy, and to urge state medical societies to advocate on behalf of such legislation.

Four resolutions were introduced pertaining to tort reform and the current professional liability insurance crisis. The College offered language to address the issue of payment methodologies and reimbursement for professional liability expenses. A resolution was passed that makes tort reform a top priority for the AMA. It also directs the AMA to work with other organizations to develop and implement a comprehensive strategic plan to achieve malpractice reforms at both the federal and state levels.

A resolution originally introduced by the College at a previous meeting of the Young Physician Section was considered and

adopted by the House of Delegates. This resolution dealt with the collection and dissemination of information from third-party payors concerning which CPT modifiers they accept.

Division of Education

Reorganization

The College's educational programs and activities are now housed in the Division of Education. An Associate Director has been recruited to facilitate achievement of the goals of this division.

Clinical Congress

Planning for the 2002 Clinical Congress in San Francisco, CA, is progressing well. Significant changes in the program of this Congress include the following: the Opening Ceremony and the American Urological Association Lecture have been combined on Monday morning; the meeting will conclude on Thursday, with the scientific sessions ending at noon; the Martin Memorial Lecture is scheduled for 1:00 pm; and the Annual Meeting of Fellows and Initiates, the Assembly of Initiates, and the Convocation will also begin at an earlier time.

The length of many general sessions and didactic postgraduate courses has been shortened, and the entire process for submitting abstracts for the Surgical Forum will be handled electronically. Plans are also being developed to create new education products based on sessions that are videotaped.

Spring Meeting

Planning for the 2002 Spring Meeting in San Diego, CA, is proceeding well. The Opening Session, "A Town Meeting: The 21st Century Health Care System," will include renowned speakers and topics of interest to all attendees.

Surgical Education and Self-Assessment Program (SESAP)

Since the release of SESAP 11 in October 2001, enrollment in the program has real-

ized an increase over enrollment in SESAP 10 during a similar period. Planning for SESAP 12 has commenced with changes that include a closer link between the topics encompassed by the Recertification Examination of the American Board of Surgery and the SESAP items. SESAP items will include more comprehensive coverage of the General Competencies. Opportunities to enhance the program technologically will be explored.

Surgeons as Educators

The ninth Surgeons as Educators course will be held at the University of Florida Hotel and Conference Center in Gainesville, FL, February 23-March 1, 2002. The course is again oversubscribed.

Committee on Surgical Education in Medical Schools (CSEMS)

Steps have been taken to pursue a model recently proposed by the CSEMS. This model includes four categories of opportunities for faculty to teach medical students during the first two years of medical school: academic, professional, personal, and planning. The Division of Education will encourage surgery faculty to participate in these endeavors and offer educational guidance to facilitate such participation.

Other national organizations

New lines of communication have been established with various national organizations, and educational endeavors will be pursued collaboratively with these organizations.

Educational grants

Implementation of the educational grant, "Educating Surgeons in Patient Safety," awarded by the Agency for Healthcare Research and Quality (AHRQ), is under way. Opportunities to develop educational projects in collaboration with academic surgery departments are currently being explored.

Division of Member Services

The division is responsible for the following functions:

- Chapter activities and meetings
- Board of Governors activities and the activities of its eight working committees
 - Nominating Committee of the Board of Governors
 - Nominating Committee of the Fellows
 - Credentials of applicants
 - Maintenance of Fellowship
 - Central Judiciary Committee of the Board of Regents
 - Advisory Councils for the Surgical Specialties
 - Added value to membership
 - Member recruitment
 - Candidate and Associate Society
 - Committee on Young Surgeons
 - International Relations Committee
 - Scholarships Committee
 - Job Bank
 - Archives
 - Committee on Women's Issues
 - Committee on Diversity Issues
 - High School Visitation Program
 - Member Services Committee of the Board of Regents
 - Resource for external inquires on surgery and ACS
 - Approvals for release of listings of ACS members

The International Relations Committee is currently collaborating with the Board of Governors' Committee on Socioeconomic Issues in its efforts regarding volunteerism and the establishment of an electronic database on our Web site.

Plans are currently being made for: the New Governors' Orientation at the Spring Meeting in San Diego, CA; the Young Surgeons Representatives Meeting/Chapter Leadership Conference during the month of May in Chicago, IL; and the Candidate and Associate Society program at the Clinical Congress in San Francisco, CA.

Some of the goals that have been set for the coming months are:

- Review and revise the applications process.
- Develop customer service center or resource center.
- Review Membership Survey in depth and bring forth recommendations to the Board of Regents.
- International recruitment of Fellows and Chapter formation.
- Investigate the feasibility of expanding categories of membership to include allied health professionals and medical students.
- Prepare follow-up letters to Candidates and Associates who do not renew concerning their reasons.
- Enhance and update data collection system.
- Develop new benefits for members.
- Investigate the feasibility of association management of regional and specialty surgical organizations.
- Generate committee workbooks on electronic media.
- Decentralize educational programs.

Advisory Councils for the Surgical Specialties

The Advisory Councils continue to encourage specialty surgeons who pass their boards to apply for ACS membership. Surgeons who do not yet meet the minimum requirement are encouraged to become members of the Associate Fellows Group until they are eligible to apply for Fellowship. Similarly, several Advisory Councils have sent letters to their specialty program directors who are not currently Fellows encouraging their affiliation with the College and encouraging participation from their residents in the College's Candidate and Associate Society.

The Advisory Councils continue to submit specialty articles for publication in *JACS*. In addition, they continue to provide recommendations for the "What's New in Surgery?" presentations published throughout the year in *JACS*.

The Advisory Councils continue to develop specialty-sponsored programming presented at the Spring Meeting and the Clinical Congress. The Advisory Council Program Representatives are collaborating with the Program Committee and the Division of Education as it examines the Clinical Congress structure, schedule, and educational offerings.

The Regents approved a request from the Advisory Council for General Surgery to add the Texas Surgical Society to the official list of approved surgical societies in the ACS membership directory database. The Regents also approved a request from the Advisory Council for Cardiothoracic Surgery to approve the nominations of Robert Replogle, MD, FACS, and Constantine Mavroudis, MD, FACS, to the Joint Council on Thoracic Surgery Education.

International Relations Committee

In 2001, the International Relations Committee received a record-breaking number of completed applications. In view of the large number of excellent applications and the small number of scholarships awarded, the committee recommended that additional scholarships be awarded. The Board of Regents awarded three additional International Guest Scholarships for 2002.

The committee will work with the international chapters and the Development Office to find support to initiate an ACS Travelers program along the lines of the existing Australia and New Zealand Chapter of the ACS Travelling Fellowship.

Scholarships Committee

The Regents approved a request from the Scholarships Committee to award 10 ACS Faculty Research Fellowships for 2002-2004.

Board of Governors

The chairs of the eight Governors' committees made various recommendations to the full Board following their annual com-

mittee meetings in October 2001. The Board of Governors approved all recommendations, after which they were presented to the Board of Regents for information.

Division of Research and Optimal Patient Care

Interim Director

Alden H. Harken, MD, FACS, ACS Regent, will fill this position on a part-time, temporary, and transitional basis.

Cancer

The Commission on Cancer Approvals Program exceeded by 18 percent its 2001 goal to survey 404 cancer programs, completing 480 surveys. Seven cancer program networks successfully completed the survey process utilizing the new standards released in 2001 for network cancer programs.

A Facility Information Profile System was established as a collaborative effort between the Commission on Cancer and the American Cancer Society as a benefit for approved programs to share their cancer program information with the public. This program is in line with the College's mission to increase consumer-based education.

The National Cancer Data Base (NCDB) plans to release the *NCDB Benchmark Reports* in March. The availability of the *Reports* should enable physicians and cancer registrars to identify patterns of care in their institutions that differ significantly from patterns in similar institutions, or differ from state, regional, or national norms.

More than four decades worth of work among the American Joint Committee on Cancer, the International Union Against Cancer, committed and eminent clinicians, and dedicated staff will culminate in the publication of the *Cancer Staging Manual, 6th Edition* by a new publisher, Springer-

Verlag, at the American Society of Clinical Oncology annual meeting in May 2002.

Office of Evidence-Based Surgery

The Patient Safety in Surgery (PSS) study is a joint collaboration between the Veterans Administration (VA) and the American College of Surgeons to evaluate the effectiveness of the VA's National Surgical Quality Improvement Program (NSQIP) as a patient safety reporting system. The evaluation includes the expansion of NSQIP into private-sector hospitals. The main focus for the study over the next six months is to monitor the surgical case accrual and data quality at 12 participating private sector hospitals to ensure that the NSQIP is operating appropriately in these institutions.

The Work Conditions of Surgery Residents and Quality of Care study involves assessment of the relative importance of stress factors on the performance of surgical residents, and evaluation of how these factors relate to the quality of care the residents provide. This study is a cooperative effort among the American College of Surgeons, the VA's NSQIP, and The University of Texas at Austin Human Factors Project. Because both this study and the PSS study rely on implementation through the VA's NSQIP system, the two studies will be managed together.

Trauma

David B. Hoyt, MD, FACS, of San Diego, CA, will fill the position of Medical Director of this section.

Trauma Education Endowment Fund

The Regents approved the recommendation to establish a Trauma Education Endowment Fund. An opportunity exists for the ACS Committee on Trauma to lead the College in the development of trauma education outreach in the world, especially in resource-challenged countries. The purpose of this fund would be to: "Improve the qual-

ity of trauma care around the world through established ACS trauma education programs and to help resource-challenged countries implement such trauma education in their countries."

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☐ I am a PARTICIPANT in the ACS Candidate Group and have paid my current dues. Candidate ID # _____	\$160. \$
☐ I am a RESIDENT in a surgical residency program accredited by the Accreditation Council for Graduate Medical Education and listed in the Graduate Medical Education Directory. A LETTER IS ENCLOSED from my program director or administrator.	\$215. \$
☐ I am none of the above, but wish to enroll.	\$475. \$

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thank you
for participating



Letters

The following comments were received in the mail or via e-mail regarding recent articles in the Bulletin and the "From my perspective" columns written by ACS Executive Director Thomas R. Russell, MD, FACS.

PDA's

Your articles in the January and February *Bulletin* about surgeons' use of personal data assistants (PDAs) were informative and excellent. I would like to add that I have used my PDA at the point of contact in the office, operating room, and hospital to collect data for inguinal hernia research. I found thinkingBytes software most useful in setting up the program.

**Harold S. Goldstein,
MD, FACS**

War on drugs

Legalization of "hard" drugs (October 2001)? At what user age will the legalization become illegal? Surely it is not proposed by Drs. Gans, Blain, and Lucas that teenyboppers have free access. But with legalization they will get it more easily than presently. And there's your illegal drug market again. Are we going to decriminalize DUI, including all the mind benders? And what about our surgeons, pilots, operators of large machines, and corporate chieftains? Many of the latter appear to have been UI for the past six or seven years. Our welfare depends on these people. The war on drugs is no more a failure than the war on crime. Crime will always be with us and it is not a war that is expected to be "won" in the sense of "finished." The war on crime must be fought constantly, endlessly, and at great expense. The safety and stability of our society depends on it.

William S. Lyons, MD

I felt that I just had to add my comments to the question of our

government's drug policy and the spread of hepatitis and AIDS.

It is obvious that we have lost the so-called war on drugs. Like Prohibition, it has engendered corruption.

I worked in the New York State drug program in the late 1960s and 1970s, prior to my retiring for health reasons, when Governor Rockefeller started treating illegal drug use as a medical problem. The object was to change the user from heroin to methadone. The criteria were that individuals had to maintain a stable relationship, be employed, and keep out of trouble with the law.

I worked at a center (a former medium security prison) for recidivists in Woodbourne, NY. We had 600 male residents, from illiterates to physicians. They came from all over the state. We had a drug-free cure rate of about 2-3 percent, but about a 70-80 percent cure rate for individuals on methadone who met the criteria I just described.

I analyzed the figures in 1970. The operating cost for the center was \$4 million. This sum included staff salaries as well as food, heating, electricity, and so forth. The average habit cost \$20 per day. Including shelter, food, and so forth, it cost a minimum of \$10,000 a year for residents. The vast majority of residents were of low-income status, but they all possessed "street smarts" and made their living by robbery, pimping, and so forth. They were in no shape to do comparison shopping for the best price from the fences who handled the stolen property. The average price they received for stolen goods was about 10 percent of its actual value, so these individuals had to steal \$100,000 of property to obtain the \$10,000 they needed each year to live.

Six hundred times \$100,000 equals \$60 million in assaults against the public. In the commission of these assaults, a certain

number of citizens were injured or killed. Keeping these 600 individuals in a locked facility cost only \$4 million. I changed my mind and decided the program was worth the cost.

I would like to point out that Daytop, Evergreen, and other drug rehabilitation/private rehabilitation programs claimed success rates of 70-80 percent. However, their clients came to them voluntarily. They had to wear a placard around their neck for three months that said "I am a junkie." If they stuck out the time, they were accepted into the program. The counselors were all reformed addicts. Following the completion of the program they were usually placed in a different social milieu.

Our residents came from the court system and, after a three-year stay, went back to the same social milieu they came from.

Following the repeal of Prohibition in 1933, our streets became much safer. There was no rise in the alcoholism rate. I am sure with the repeal of drug laws our prisons will be less full and the money can be used for rehabilitation. Our citizens and their property will be safer. Hepatitis and AIDS rates will fall. There will be much less malfeasance in law enforcement.

Disease-wise and financially it is time to change our drug laws.

**Stanley A. Kornblum,
MD, FACS**

Medicare

Thank you for your representation of surgeons in the U.S. The American College of Surgeons remains the one reliable bastion of support that physicians can count on.

With respect to Medicare, this operation is flawed in the extreme. I have "opted out" of the system for over three years now. My Medicare patients are uniformly understanding. I provide discounted service to individuals needing care and

thereby I am able to fulfill my obligations to provide to my patients the care they need.

In reality, my experience has been one that financially has improved my "bottom line." Now, no longer are we caught in the plethora of paperwork, appeals, and blunders at the CMS management level. The reduction in the paperwork and the reduction in the tension of dealing with a punitive and overbearing "insurer" has been liberating in the extreme. And, despite the opting out of the program, the percentage of Medicare patients in my practice has not changed.

Finally, one last comment: it is ludicrous to reduce the reimbursement for health care services on an annual basis in the face of continuing increases in the cost of living and the expenses of providing care. How any adults of normal intelligence can promote this concept and expect acceptance of the logic is beyond my comprehension. Medicare RVUs are below 30 percent of the mid-range RVUs for my specialty and geographic area when I started practice in 1989. To continue to reduce the reimbursement is ludicrous.

William Wilson, MD, FACS

Careers in surgery

Neither Dr. Russell's commentary in a recent *Bulletin* about careers in surgery nor the subsequent letters to the editor mentioned the rise of female medical students as one reason for the potential shortage of surgical residents.

Recently I, a 72-year-old retired internist, and a colleague analyzed this feminine transition in American medicine (the study was the subject of a master's degree final thesis written in conjunction with Ms. Robin D'Errico).

Currently, some 44 percent of American medical students are women, and this group has had a

profound effect on all residency programs. Female physicians overwhelmingly select the primary care specialties. In both pediatrics and obstetrics/gynecology residency programs, women already constitute almost 70 percent of the trainees. On the other hand, women fill only about 22 percent of the surgical residencies and even fewer in orthopaedics, urology, and neurosurgery.

In our interviews with female physicians, they offered several reasons for this disparity. While some women cited a lack of female surgical mentors along with harassment, especially during medical school surgical rotation, the principal reason for eschewing surgery seemed to be the rigors and time constraints both in surgical training and surgical practice. Prime reproductive and residency years collide and female physicians make career decisions with families in mind. Women physicians remain the primary providers of child care. They practice fewer hours, preferring to be employees rather than solo or small group practitioners. Still, the strain of dual careers is often overwhelming, with higher rates of depression and divorce than their male counterparts.

In one Canadian study of female surgeons, 12 percent voiced dissatisfaction over the conflict between home and professional responsibilities.

Our study concluded that there was a high probability of shortages of qualified candidates in several surgical specialties. The likelihood becomes greater as the percentage of female medical students reaches parity with, or even surpasses, male students. (Thirty-five medical schools already admit more female than male applicants.) Female surgeons and surgical program directors both agreed that to attract and retain more qualified female surgical residents, significant modifications in surgical training pro-

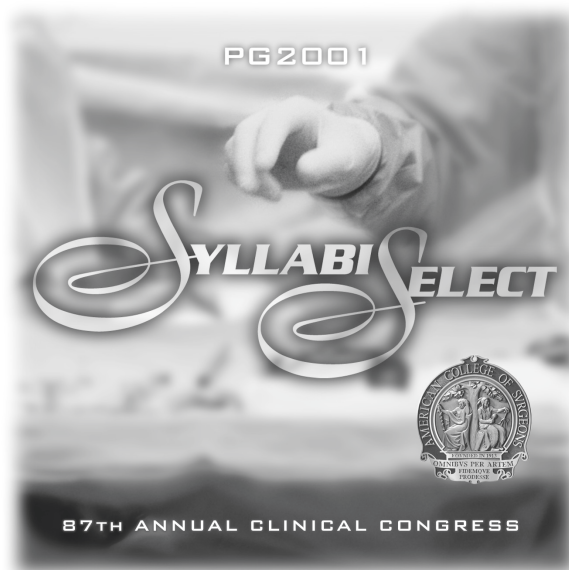
grams—including longer part-time residencies—are needed.

Such changes seem inevitable. Currently, 60 percent of the female physicians are under 45 years of age, while an equal percentage of male physicians are above that age. In the next two decades, women will represent almost 40 percent of the physician population. Female physicians will bring a new perspective to both the practice and politics of medicine.

In addition to the changing physician demographics, in 20 years there will be 12 percent more women over the age of 65 than men. Women, often with a preference for female physicians, are the biggest consumers of health care. This double force, female physicians and female consumers, will have a prominent voice in the delivery of health care.

Is it possible that some specialties will become female enclaves while others, in the surgical fields especially, remain dominated by male physicians? Such a situation would markedly limit a patient's choice of physicians. The "feminization" of medicine could create a dilemma for the American College of Surgeons.

Lee Sataline, MD, FACP



Postgraduate course syllabi now available on CD-ROM

A CD-ROM containing select postgraduate course syllabi from the 2001 Clinical Congress is now available for purchase through the College's Web site at <https://secure.telusys.net/commerce/current.html> or by calling 312/202-5474.

Twenty courses are included on the CD-ROM, which is available for \$35. There is an additional charge of \$12 for shipping and handling for international orders.

The CD-ROM contains syllabi from the following postgraduate courses:

- Professional Liability and Risk Management in a Changing Health Care Environment
- Head and Neck Surgery
- Diseases of the Liver, Biliary Tract, and Pancreas
- Vascular Surgery
- Thoracic Surgery
- Current Controversies in Cancer Management
- Gastrointestinal Disease
- Minimal Access Surgery
- Clinical Update in Trauma
- Cardiac Surgery
- Laparoscopy and Urology
- Surgical Infection and Antibiotics
- Breast Disease
- Pre- and Postoperative Care (Nutritional Support)
- Anesthetic Innovations for Improving Surgery and Postoperative Pain Control
- Practical Operating Room Management for Surgeons
- Complex Hemangiomas and Vascular Malformations
- Perioperative Care of the Anemic Patient
- Colon and Rectal Surgery
- The Anatomy and Surgical Correction of Groin and Abdominal Wall Hernias



Chapter news

by Rhonda Peebles, Manager of Chapter Services, Division of Member Services

To report your chapter's news, please contact Rhonda Peebles toll-free at 888/857-7545 or via e-mail at rpeebles@facs.org.

Louisiana marks 50th year

The Louisiana Chapter observed its 50th anniversary January 12-13. Paul E. Collicott, MD, FACS, Director, Division of Member Services, presented a commemorative charter to the officers and Governors of the Louisiana Chapter (see photos, this page). The education portion of the annual meeting featured presentations by four visiting professors, as well as chapter officers, former officers, and surgical residents.

Southern California holds joint meeting with CA Trauma Conference

In response to members' demands for more condensed and economical education programs, the Southern California Chapter held its 2002 annual meeting in conjunction with the annual California Trauma Conference, which is sponsored by the Southern California Committee on Trauma. Nearly 300 Fellows, Associate Fellows, Candidates and residents, and trauma nurses attended the joint conference. In addition to three visiting professors presenting educational sessions, an extensive residents' competition was conducted. The winners included:

First Place: Diana Yoon, MD, Olive View-UCLA Medical Center, "Human Cytokine in Nonperforated vs. Perforated Appendicitis: Molecular Serum Markers for Extent of Disease?"

Second Place: Jason Q. Alexander, MD, Huntington Memorial Hospital, "Is Duplex Ultrasonography an Effective Single Diagnostic Modality for the Preoperative Evaluation of Peripheral Vascular Disease?"

Third Place: Daniel R. Reichner, MD, University of California-Irvine, "Laser Flap Delay: Comparison of ER: YAG and CO₂ Lasers."

Also during the meeting, the Southern California Chapter observed its 50th anniversary. The



Louisiana Chapter: Dr. Collicott (left) presents the 50th anniversary commemorative charter to William E. Weldon, MD, FACS, Immediate Past-President of the chapter.



The Louisiana Chapter officers and Governors pictured include (left to right): Chapman Lee, Past-President; C. Edward Foti, President-Elect; J. Patrick O'Leary, Governor (and Chair of the College's Board of Governors); Dr. Weldon; James L. Nelson, President; Lester W. Johnson, Governor; and Joseph F. Uddo, Jr., council member (all MD, FACS).

chapter's commemorative charter was presented by R. Scott Jones, MD, FACS, the College's President (see photo, p. 63). New officers also were elected (see photo, p. 63).



Southern California Chapter: Dr. Jones (left) presented the 50th anniversary commemorative charter to Samuel E. Wilson, MD, FACS, President of the chapter.



The officers and Governors of the Southern California Chapter include (left to right): Theodore X. O'Connell, Vice-President (and State Cancer Liaison Chair); Fred Weaver, President-Elect; Kenneth S. Waxman, Recorder and Governor; Stanley R. Klein, Secretary-Treasurer and Governor; Dr. Wilson, President and Governor; Gil Cryer, State COT Chair; John C. German, Governor; Richard A. Dorazio, Immediate Past-President (all MD, FACS); and C. James Dowden, Executive Director.

Last call

The deadline to register for the combined Chapter Leadership Conference and Young Surgeons Representatives Annual Meeting is May 10. This year, the combined education program will take

place May 15-18 at the College's headquarters. A preliminary agenda includes:

May 15, Chapter Administrators and Executive Directors:

- Legal Update.
- Networking/Alliances/Coalitions—Sharing the Burden (and Expense) of Advocacy.

May 16, Chapter Officers, Chapter Administrators, and Executive Directors (Young Surgeon Representatives invited):

- Legal Update.
- Enhancing the Value of Membership through Mentoring.

• Organizing for Action: Building a Plan That Gets Results.

May 17, Chapter Officers, Young Surgeons, and Executive Directors:

- Update on ACS Activities and Programs.
- Report from the ACS Committee on Trauma on Bioterrorism Preparation.
- Plenary Session—Current Membership Issues for Chapter Leaders.
- Workshops (select one): Advocacy—State and federal; Membership communications and recruitment; Planning education programs to meet members' needs.

The deadline for reserving rooms at the Wyndham Hotel for the meeting is April 14. For hotel reservations, call 312/573-0300. For more information on this year's Leadership and Young Surgeons' education programs, please call 888/857-7545.

Chapter anniversaries

Month	Chapter	Years
March	Brazil	50
	Southern California	50
	Massachusetts	37
	Nevada	37
	New Hampshire	50
	Puerto Rico	52
	South Dakota	50
April	Metropolitan Chicago	47
	Mississippi	49
	Oklahoma	52

Additional guest scholarships awarded

The ACS Board of Regents agreed at its February meeting to award three additional International Guest Scholar-

ships for this year. The additional scholars are: Farhat Abbas, MD, Karachi, Pakistan; Luis Gramatica, Jr., MD,

Cordoba, Argentina; and Manuel Francisco Tanada Roxas, MD, FPCS, Las Pinas, Philippines.

Next month in *JACS*

The May issue of the *Journal of the American College of Surgeons* will feature:

Original Scientific Articles:

- Achieving R0 Resection for Locally Advanced Gastric Cancer: Is It Worth the Risk of Multi-Organ Resection?
- Transanal Excision of Locally Advanced Rectal Cancers Downstaged Using Neoadjuvant Chemoradiotherapy

Education

- Spirituality in Surgical Practice

Palliative Care Series:

- Who Should Manage the Dying Patient?: Rescue, Shame, and the SICU Dilemma

What's New In Surgery:

- Transplantation
- Cardiac Surgery

